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The Journal

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Canada, US plan joint drug strategy: Kaplan

By Anne MacLennan

OTTAWA — Plans are being studied for a joint Canada-United States attack on drug traffickers, says Canada's solicitor general.

Robert Kaplan told **The Journal** he expects to announce early stages of a formal link between federal enforcement agencies of the two countries early this month.

He said he had been discussing the possibility with the chief of US Vice-President George Bush's inter-agency task force, and the Royal Canadian Mounted Police (RCMP) are now examining the idea with US authorities.

"What they (the Americans) have in mind is to stop targetting their interdiction program (exclusively) on the Canada/US border and do it on a continent-wide basis," he said.

The enforcement agencies "would work together to make the boundaries of the program the Atlantic and Pacific instead of the border. There'd still be all of the existing programs, but this new interdiction program would have cooperation along both coasts as well."


Kaplan

For now, enforcement authorities operate within diplomatic channels, with officers attached only to the embassy of the other country. Formal links would allow more cooperation and easier access for narcotics officers to cities, regions, and coastal waters of the other country.

At **The Journal**'s press time, Mr Kaplan was expected to announce the proposal with his release of the RCMP's second annual National Drug Intelligence Estimates 1982 (With Trend Indicators Through 1985). The reports shows a significant increase in both heroin and cocaine traffic into Canada in 1982 over 1981 (**The Journal**, Feb, 1983). (See related stories on page 1 and The Back Page.)

Mr Kaplan said the joint-action proposal is part of an "intensified effort" by the federal government against drugs.

He said the effort will include increasingly heavy emphasis by the RCMP on tracking major drug trafficking conspiracies.

"Ever since we got authority (in 1976) to wiretap, we've been busting individuals at higher and higher levels in the trafficking business, and there are quite a lot of rich inmates right now because of that. Before 1976, there weren't. We were just getting people who actually handled the drugs."

Other initiatives will include increased cooperation among the RCMP and provincial and municipal police forces "to maximize resources" in drug cases, and the transfer of 61 experienced RCMP officers to the drug enforcement branch.

"We know from the beginning that we can't eliminate drugs from this society. What we can do is send out a signal that those who are involved in the drug trade are risking the consequences demonstrated in the headlines."

Mr Kaplan said that as chief authority for federal law enforcement and the federal penitentiary system, he has an "interesting perspective."

"Even in our penitentiary system we can't keep drugs out. Look at the amount of control we have.

"And even with that, there are drugs in every one of our institutions.

"I just don't think it would be acceptable to Canadians to have the amount of police action that would be required to stop drugs completely from entering Canada. So, we want to be more effective with the police presence we have."

More cocaine, heroin hitting Canada

By Anne MacLennan

OTTAWA — Record high amounts of cocaine and dramatically increased amounts of heroin are now entering Canada.

And the trend is likely to continue through 1984 and 1985, says the chief of the drug enforcement branch of the Royal Canadian Mounted Police (RCMP).

The cocaine will translate directly into more Canadian users; it could also become a replacement drug for marijuana users, warns Superintendent Rodney T. Stamler.


Stamler

The heroin — far more than is estimated to be required for Canada — is believed by officials to be destined largely for trans-shipment to other countries, particularly the United States.

However, they are still not certain.

"Some of it is for the US, some we don't know where it's headed. It's coming in, and we don't know its final destination," Supt Stamler told **The Journal**.

The sheer quantity, however, increases the potential for more heroin use in Canada and raises fear among enforcement officials that major Canadian cities that are distribution centres — Montreal, Toronto, and Vancouver — could attract satellite networks of top international criminals.

Supt Stamler said if the heroin is indeed for distribution to other countries, then cocaine is the RCMP's chief concern. If the heroin is for Canada, however, "then that is serious."

Drugs and the laundering game
The Back Page

He said cocaine is now "very, very popular all through North America and Europe, and its popularity is increasing."

Purity levels are up, prices are dropping, and "people who couldn't afford it a while back are now able to.

"It's sought after by people who formerly would have used hash or marijuana and, in a lot of areas, it's replacing marijuana."

The RCMP's most recent, complete statistical picture is for 1982 and is contained in its second National Drug Intelligence Estimates 1982 (With Trend Indicators Through 1985) which is expected to be released this week by Solicitor General Robert Kaplan.

However, as 1983 drew to a close, Supt Stamler said it was already clear there is now close to three times as much heroin entering Canada as a year ago, and about 20% more cocaine. And cocaine production in South America is up 75% or more.

It's clear, he said, "the enforcement of criminal law will never prevent drug use in our country. We can only use it as a deterrent; that's all criminal law is intended to do."

Commenting on the continued growth in drug production, and the incredible profits in drugs — to Colombia, marijuana means $2 billion annually in hard currency — Supt Stamler allows "trying to curb production is almost impossible.

"I don't see any solution in sight in the short term. Crop substitution is just not working that well.

"I don't say it isn't the answer. It is in the long term. It has to be. But, if you're going to stop production, you're going to have to do something else in its place, substitute other activities.

"A South East Asian opium farmer can sell for instant cash. He can sell all or part for cash. And he uses it for medicinal purposes. It's part of his heritage, his tradi-

(See — Big — page 2)

History usually repeats itself

US narcotic epidemic on way

By Harvey McConnell

ATLANTA, GA — A major narcotic epidemic, fuelled by the present cocaine epidemic, is on the way in the United States.

The first cocaine epidemic a hundred years ago led to an increase in narcotic addiction. "So will this one if history repeats itself, and it usually does," predicts Mark Gold, MD, director of research at Fair Oaks Hospital, Summit, New Jersey.


Gold: chasing the dragon

Dr Gold told the 8th Southeast Conference on Alcohol and Drug Abuse (SECAD) here that since he and his colleagues established their national "800-COCAINE" hotline in May (**The Journal**, Nov, July 83), they have received more than 180,000 telephone calls.

"It's not pleasant to say, but cocaine has become the drug of working people and influences every aspect of American life." He said most people believe they cannot become addicted to a "social" drug and are not prepared for the problems induced by cocaine abuse.

Dr Gold: "When the ultra rich and the jet-set find out that now cocaine is the drug of the middle classes, what do they do? Chase the dragon" (snort heroin and smoke opium). Already in New York, Los Angeles, and San Francisco there has been a significant rise in these practices, he said.

Dr Gold commented later that about one-third of the hotline callers who are freebasing cocaine are also using heroin. Since 40% have incomes of more than $50,000 a year, they are quite distinct from street heroin users.

Most cocaine users smoke or snort heroin to moderate the increased levels of cocaine which have made them so jittery they find it difficult to work. At this level of use, "they need to do something to take the edge off, and heroin is like a natural antidote."

Dr Gold five years ago conducted the first successful clinical trials with the anti-hypertensive clonidine to reduce the effects of heroin withdrawal. His latest research has been with naltrexone, which helps recovering addicts through the period following detoxification.

With the two drugs now available — naltrexone will be marketed by the DuPont company within the next six months — "we really have a chance to treat them, to get them back to full functioning and not always think that the needle barrier is a bridge that once you cross you can't return."

Dr Gold said the concept of "recreational drugs" is a dangerous one but that until now heroin has never been referred to as "recreational." He said it may be that chasing the dragon, snorting, or skin popping will be referred to in the future as recreational narcotic use.

Florida MD will replace Mayer as ADAMHA chief

By Harvey McConnell

WASHINGTON — Florida pediatrician Donald MacDonald has been chosen by United States President Ronald Reagan's administration to succeed William Mayer as head of the Alcohol Drug Abuse and Mental Health Administration (ADAMHA).

Dr MacDonald is president of the scientific board of the American Council for Drug Education and is a member of the board of the National Federation of Parents for Drug-Free Youth.

Subject to Congressional approval, he will assume the post vacated by Dr Mayer who has become a secretary of defense for health affairs, US department of defense.

A native of New York, Dr MacDonald was educated at Williams College, Williamstown, Mass, and Temple University School of Medicine, Philadelphia, Penn. He established a pediatric practice in Clearwater, Florida in 1962.

He is currently associate professor of pediatrics at the University of South Florida School of Medicine, Tampa; a fellow of the American Academy of Pediatrics; chairman of the drug abuse committee of the Florida Medical Association; and director of clinical research for STRAIGHT, the drug abuse prevention and treatment program for adolescents, located at St Peterburg.

Dr MacDonald is also past president of the Florida Pediatric Society and Florida chapter of the American Academy of Pediatrics.

INSIDE
Marijuana
Answers for Young People and Parents
A supplement S1-S4

NEWS

Downward trend in tobacco use stops

Alcohol, pot use down among Ontario students

By Terri Etherington

TORONTO — There has been a significant increase in the non-medical use of stimulants among Ontario students, but use of alcohol and cannabis has declined slightly, says a province-wide survey of student drug use.

However, an earlier trend toward declining tobacco use by young people appears to have stopped. The significant reduction in the number of students reporting smoking between 1979 and 1981 did not continue into 1983.

In the 12 months prior to the 1983 survey, 15.4% of students reported using stimulant drugs — other than those taken on the advice of a physician — as compared to 12.1% in 1981. Stimulants were described in the survey as "beans, Christmas trees, black beauties, diet pills, etc."

Increases were reported mainly among males, among those 18-years and older, and in the Metro Toronto and Northern Ontario regions.

Stimulants replaced medical barbiturates as the fourth most commonly used drugs, following alcohol, tobacco, and cannabis.

However, the survey reports, "the increasing availability of pseudo-amphetamines ('pills intentionally made to look and sound like amphetamines') may, in part, account for some of this increase."

In the fourth biennial, province-wide survey by the Addiction Research Foundation (ARF) here, alcohol retained its place as the drug used by the greatest number of students. But it was not the drug students used most frequently.

By far the most frequently used drug was tobacco — used daily by 69.2% of smokers in the 12 months prior to the survey. Those reporting smoking at least once in the 12 months dropped to 29.1% from 30.3% in 1981.

Females no longer reported significantly higher rates of smoking than males (30.1% of girls compared to 28.1% boys).

Alcohol was used by 71.7% of all students in 1983, down from 75.3% in 1981. But, 56% of all students and 79% of alcohol users reported drinking only two or three times a month or less; daily drinking among students was uncommon (0.6% of users).

Cannabis ranked third among Ontario students in prevalence of use and second in frequency of use by users.

Of the students surveyed in grades 7, 9, 11, and 13 (grade 5 was also surveyed but results for this group are not included in the 1983 preliminary report*) 23.7% reported they had used cannabis at least once in the 12 months prior to the survey, as compared to 29.9% in 1981. Of the cannabis users, 32.4% reported using only once or twice, and 19.5% said they used cannabis 40 times or more in the preceding year.

However, the researchers report, "the overall declines in alcohol and cannabis use . . . are possibly the result of a greater proportion of younger students in the 1983 sample."

This factor may also account for a slight increase in students reporting glue sniffing, to 3.2% in 1983 from 2.3% in 1981. Glue and other inhalants are characteristically used by younger students.

"The possibility of declining rates of cannabis and alcohol use among the total sample appears to be promising," say ARF researchers Reginald Smart, PhD, director of program development, research development department; Michael Goodstadt, PhD, chief of educational research; Margaret Sheppard, research associate, educational research; Godwin Chan, senior research assistant, educational research; and Edward Adlaf, senior research assistant, drug control research.

The authors note that one recent survey has demonstrated a decrease in cannabis use (**The Journal**, April 83) and another, a decrease in both cannabis and alcohol use.

The ARF group says, however, "increases in rates among subgroups, in particular among older male students, are cause for concern."

Overall, the survey shows the prevalence of drug use generally peaked by grade 11 (ages 15 to 16 years), with the exception of glue sniffing. Drug use was generally more conservative among those 18 years and older (grade 13).

Among females, use of alcohol and cannabis declined significantly, and there were no significant increases for any drug use among females.

Regional differences in drug use were less dramatic than found in 1981.

**Preliminary Report of Alcohol and Other Drug Use Among Ontario Students in 1983, and Trends Since 1977* — Addiction Research Foundation, 33 Russell St, Toronto, Canada M5S 2S1.

Briefly...

Valium, cleft palate

BOSTON — Evidence from more than 3,000 cases in Canada and the United States appears to refute earlier studies linking mothers' use of Valium (diazepam) during pregnancy with birth defects such as cleft palate and cleft lip in their babies. A report on the recent study in the *New England Journal of Medicine* indicates there was "little reason to believe" those earlier conclusions.

Brake fluid imbibing

LONDON — Brake fluid containing ethylene glycol is "not infrequently" consumed by heavy-drinking South African garage workers craving alcohol, reports Dr D. A. van Staden, of the University of Pretoria, in the *South African Medical Journal*. He says many cases of acute poisoning and coma "of unknown cause" may be a result of brake fluid consumption.

Alcohol deaths hidden

TORONTO — British law requires a post-mortem if death is linked to alcoholism. Thus, says Professor Dame Sheila Sherlock of London's Royal Free Hospital, British physicians often refuse to note alcoholism on death certificates in case post-mortem results adversely affect life insurance payments to survivors. She addressed the Scientific Congress here of the British Medical Association.

Cigs affect sex drive

TORONTO — Recent research suggests heavy smoking among men may be linked to a decline in sexual activity. Two French studies reveal men aged 25 to 40 years who smoke one or more packs of cigarettes daily experience less sexual activity than non-smokers in the same age group. And a study of United States servicemen confirmed impotence is more common among heavy smokers, the *Toronto Star* reports.

Top marks to The Journal in national competition

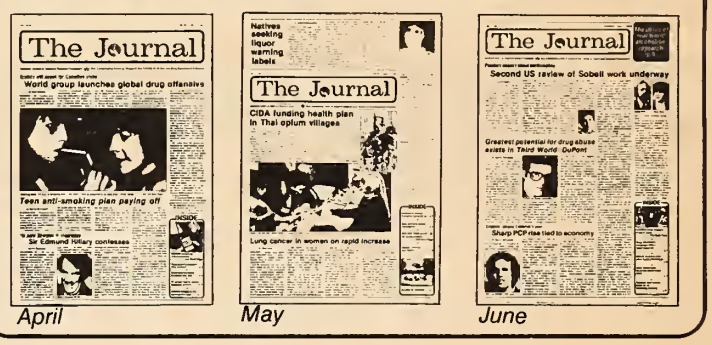
TORONTO — **The Journal** has received a first-place Award of Distinction in a national competition organized by the Health Care Public Relations Association (HCPRA).

The Journal won the award in the magazines/newspapers category for its submission of three consecutive 1983 editions (April, May, June). Judges in this category were Robert Fulford, editor of *Saturday Night* magazine; Stan Fisher, director of communications at York University in Toronto; and Diane Rimstead, assistant director of health promotion for the Ontario Ministry of Health.

Betty Lou Lee, a regular freelance correspondent for **The Journal**, received a third-place award in the external media category for her article on new classes of drugs for heart disease. The article was published in *The Spectator* in Hamilton, Ont, where Ms Lee is a medical writer.

The HCPRA, an affiliate of the Ontario Hospital Association, is the only organization in Canada whose main objective is the improvement of public relations in health care settings. More than 170 hospitals and health care agencies are members. In this fourth annual competition, 58 health care centres across Canada submitted entries in nine separate categories.

The Addiction Research Foundation, which publishes **The Journal**, also received a HCPRA first-place award for a 14½-minute videotape, Butt-It-Out, produced in 1983 by audio-visual productions. The tape uses puppetry to promote a non-smoking message to primary school children.



April May June

A pivotal battle for amateur sports

Begin, MDs protest cigarette-sponsored skiing

OTTAWA — A coalition of health interests has gained some powerful support in its drive to have the RJR-Macdonald tobacco company sponsorship withdrawn from the Canadian Ski Association's (CSA) national ski championships this spring.

The coalition, which is lead by some of the CSA ski team doctors, and representatives of the Canadian Cancer Foundation and the Non-Smokers Rights Association (Toronto), recently announced that federal Health and Welfare Minister Monique Begin and the Canadian Medical Association (CMA) were supporting their stand.

The coalition was formed last October after the CSA agreed to accept a five-year, $1.7 million sponsorship of the national ski championships from the RJR-Macdonald company.

Initially, the sports doctors made a representation to the alpine section of the CSA which decided to drop its association with the company on Oct 30, only to be overruled by the CSA executive.

The protest quickly grew as the doctors received support from groups such as the cancer foundation, non-smokers rights group, Canadian Heart Foundation, Canadian Council on Smoking and Health, and the Alberta Medical Association.

Andrew Pipe, MD, a ski team doctor and head of the Ontario Medical Association's sports medicine section, sees the protest against the sponsorship agreement as a pivotal battle in the drive to stop tobacco companies' sponsorship of amateur sports.

"I really feel if we're successful this may put an end to tobacco industry sponsorship of amateur sport," he told **The Journal**.

Late in November, the coalition asked for and was given a meeting with Ms Begin, whom Dr Pipe described as being "very receptive."

At that meeting, Ms Begin agreed to urge Fitness and Amateur Sports Minister Celine Hervieux-Payette to withdraw a large portion of the government's annual financing of the CSA, to protest the RJR-Macdonald sponsorship.

Dr Pipe said Ms Begin also agreed to reactivate the dossier calling for stricter controls of tobacco advertising, which was shelved when the industry ageed to voluntary restraints.

At the conference, David Nostbakken, PhD, director of public education for the Canadian Cancer Foundation, said the coalition had found an alternate, as yet unnamed sponsor to replace RJR-Macdonald.

Following the meeting with Ms Begin, Dr Pipe said the coalition was seeking a meeting with Ms Hervieux-Payette in an attempt to gain her support.

Despite a lack of response to these initiatives from either the CSA or the tobacco company, Dr Pipe considers the coalition has a good chance of being successful.

Whatever the end result, Dr Pipe said the issue represents a subtle change in attitude of Canadian doctors toward smoking.

"I think one of the neat parts of the story is that doctors have become involved in an advocacy thing around this issue."

It is an indication, he said, that doctors "have to focus less and less on addicted smokers . . . and more and more on issues such as this."

Big money makers are prime target

(from page 1)

tion. And the drug will keep for years. What other crop has that kind of returns?"

The cocaine supply is similar. "You can't keep it all that long, but there's an instant market, and that produces instant, hard currency. And that applies to everyone who handles the drug.

"It's very complex. If you can't get at the supply, you have to turn your attention to the user area, and that's Canada, the US, and Europe.

"And we can't seem to do very much."

For now, he said, the main hope lies in national and international attacks on the big money makers — the people at the top of the drug-profits hierarchy (See The Back Page).

"We need to stop the flow of money from drugs which, in turn, is invested back into the drugs."

NEWS

Italy takes multi-million dollar swipe at cocaine

By Behrouz Shahandeh

VIENNA — Italy has pledged the largest-ever single contribution to the United Nations Fund for Drug Abuse Control (UNFDAC) and has become, potentially, the fund's leading donor.

Its US$40.9 million "special purpose" contribution is earmarked for, but not restricted to, implementing projects in the next five years aimed at reducing illicit supply of cocaine from South America.

At the same time, it has doubled to $188,673 its annual general contribution to the fund.

The home country of the UNFDAC chief Giuseppe di Gennaro, Italy was among 24 countries that announced contributions totalling US$44,311,683 at the annual UN Pledging Conference for Development Activities in New York late last year.

Apart from the Italian special purpose contribution, this year's general pledges amounted to $3.4 million as compared to $2.3 million in 1982, and $3.48 million in 1981.

The Federal Republic of Germany pledged the largest general donation this year, $1.4 million, and, with an accumulated total of $8.9 million, ranks third behind Italy and the United States.

The US had been the biggest and most consistent contributor with a total of $35,270,000 since the fund began 12 years ago.

Another major donor has been Norway which pledged $816,327 this year, bringing its total to $7,970,382. (Canada's donation for the year of $203,000 was announced earlier in 1983.

France has also increased its contribution by 50%, and Panama and Zaire pledged contributions for the first time.

The UNFDAC is a voluntary fund established to bolster the financial capabilities of international programs aimed at the reduction of drug abuse. The Vienna-based organization operates on a two-tier programming approach through country programs and headquarters projects.

In the former, the UNFDAC supports multi-sectoral country programs which include income substitution projects, drug enforcement operations, and programs for the prevention, treatment, and rehabilitation of drug-dependent people. Headquarter activities include support for training programs, development of demand reduction approaches and technologies, and epidemiological research.

Apart from fund raising, the UNFDAC also develops projects and decides how and where funds should be spent in the narcotics control field. However, implementation and execution of programs is largely by other UN organizations. This year's significant increase in contributions is thus expected to have far-reaching implications for other UN organs and specialized international agencies.

In light of the large Italian pledge, the UNFDAC's 1984 budget is expected to be adjusted accordingly. The 1984 budget currently stands at $10,798,000 — the largest portion of which is allocated for the reduction of illicit supply of drugs. The remaining 30% is set aside for strengthening control measures, reduction of illicit demand, and research.

di Gennaro: a special purpose

Only contributions earmarked for development activities are pledged at the annual pledging conference; some governments submit their donations throughout the year. The UNFDAC has only been participating in this conference since 1981.

Prior to the November conference, the total contributions to the UNFDAC stood at $70 million, of which 50% had been provided by the US.

The UNFDAC's 1983 budget was $9.5 million for 22 projects in 10 countries and a variety of projects directed from headquarters.

Some 80% of the fund's resources are utilized in programs to combat opium. However, the conditions underlying the Italian contribution, and the fact the US has also earmarked its 1984 contribution of $2 million for the Andean sub-region and Jamaica, will create a shift toward more concerted action on cocaine.

In the past two years, several steps have been taken toward formulating effective programs for Bolivia, Peru, and Colombia to eradicate coca-bush cultivation and reduce the illicit production of cocaine.

'Self-rule, good health inseparable'

Solution to Native ills is political not medical

HAMILTON — Federal ministers John Munro and Monique Begin will soon feel the impact of a conference on special Indian and Inuit health problems.

At least 100 resolutions were passed at the end of the week-long session here which drew Native delegates from all parts of the country. The resolutions will first be sifted and analysed by officials of the Assembly of First Nations — the umbrella Native political body — and if possible solved there. Those that cannot, will be forwarded to Ms Begin's Health and Welfare department and Mr Munro's Indian Affairs department for action.

Delegates heard that the solutions to alcohol and drug abuse, suicide, and depression ultimately lie in politics, not medicine. Speakers argued that self-rule and good health are inseparable.

They said without the opportunity to design, implement, and plan their own health care programs, Native people will continue to be pawns and passive participants in a health care system concerned more with cure than prevention.

This political awareness has heightened since the November (1983) release of an all-parliamentary report. The unanimous recommendations were self-rule for Indians and Inuit and the abolition of the Indian Affairs department.

Munro: most serious threat

Begin: soon to feel impact

The conference was told how the mental and physical health of Native people continues to decline despite massive federal spending. Indian Affairs Minister Munro called the statistics "shaking in their import."

Among Indian and Inuit people:

- Respiratory diseases are five times higher.
- Illness due to accidents and violence are four times the national average and death rates two to four times higher.

The causes are no mystery: poverty, poor housing, lack of clean water, inadequate waste disposal, poor diet, and drug and alcohol abuse.

Mr Munro said drugs and alcohol pose the most serious threat. His ministry, with Health and Welfare Canada, will spend $154 million between 1982 and 1987 to remedy the problem.

But as Chief David Ahenakew, national chief of the Assembly of First Nations said: "Self-government has to be part and parcel of any discussion of health of the First Nations. It is only with self-government that we can restore a strong collective will to live and flourish."

UK may tighten opioid Rx rules

LONDON — Britain's health secretary Norman Fowler wants to introduce new, tougher measures to curb the growing problem of drug addiction.

He is to set up a working party of doctors to prepare guidelines of "good clinical practice" in the treatment of drug misuse and to consider the feasibility of extending licensing restrictions that currently cover the prescribing of heroin and cocaine to addicts to include all the opioid drugs, such as methadone, morphine and pethidine (Demerol).

Medical groups like the British Medical Association, the General Medical Council, and the Royal colleges of General Practitioners and Psychiatrists are to be invited to nominate members for the working party.

Next month in

The Journal

- **Drug abuse and industrial security**
- **Behavior therapy**

Eric Arthur Blair — 37 years on

By Wayne Howell

Columnists are traditionally granted a certain amount of licence at the end of an old year and the beginning of a new one. They can either write a cutesy Christmas piece (some little allegory about Santa and his elves) or they can assume, temporarily, an Olympian stance and predict what will happen in the year to come. And if imagination fails them completely, they can fall back on that old reliable, the 'review-of-the-year-just-passed.' If, over the course of the years, they have done all three, they can try something else.

I opt to interview Eric Arthur Blair, a man who has been dead for 34 years:

WH: Mr Blair, because of you the year we are now embarking on has a special significance for a great many people. How do you feel about that?

EAB: Well frankly I'm flattered and amused at the same time. Because I almost chose 1980 or 1982. So those years might just as easily have come to epitomize the Burtonesque vision. Or the Milesian vision or the Allwaysian vision.

WH: I'm afraid you've lost me.

EAB: Originally I was P.S. Burton. That's how I was known when I was down and out in Paris and London. After that I considered Kenneth Miles and H. Lewis Allways as pseudonyms. It was just a fluke that I chose 'George Orwell.' Of course at the time I had no idea I was going to add an adjective to the English language.

WH: Well, as you can see, not only did you add an important adjective to the language, but you also created a year that we imbue with special significance, a year we approach with trepidation.

EAB: Never underestimate the power of fiction.

WH: I don't. Especially since your fiction has come perilously close to reality. Your prediction of interminable wars in The Third World in 1984 was dead on: one only has to look at the Middle East, South-West Africa, and Central America to see that.

EAB: Well not exactly dead on: in 1947 I said there would be three superpowers squabbling over the rest of the world, and actually there are only two. But you have to admit that my fears about 'Big Brother' have become a reality — not exactly by way of two-way television as I foresaw, but by way of computer data banks and what have you.

WH: Agreed.

EAB: What surprises me, however, is that in many ways the real 1984 is more like Aldous Huxley's *Brave New World* than my projected version of it.

WH: Because of the pervasiveness of drugs?

EAB: Yes. That's something I never really took into account; I was, as you know, always a very political person and I guess for that reason I saw the future only in terms of political developments, not developments on a personal level. In that regard, Aldous was more prescient than I was. It is ironic, is it not, that in 1932, the year he published *Brave New World*, I was a police officer in what is now known as The Golden Triangle. But, at that time, I only perceived the death throes of a dying imperialism, nothing more.

WH: Well I don't really know what else you could have perceived in Burma in 1932. And, in any event, Huxley's *Soma*, the universal soporific of his imaginary future world, was used for political oppression, was it not; it kept the populace high, and in so doing it kept political agitation low.

EAB: That's right. But when I look around me — in the real 1984 — I see that Aldous was wrong as to the reasons for the prevalence of Soma. Because the amazing thing is that although there are places where governments do use drugs to manage certain troublesome segments of the population — such as dissidents in Soviet mental hospitals — these instances are rather rare; it appears to me that in most intances people take their Soma because of personal choice and governments are opposed to such activity and either try to control it or suppress it.

WH: Ah, but could not such drug-taking be an indirect result of 1984-style government. Could not people be seeking solace from the immanence of nuclear destruction, or the oppressiveness of their environment, and so on?

EAB: I grant you that you can single out instances of what you describe — heroin use in black ghettos, for instance — but to me the amazing thing is that the vast majority takes its Soma or 'Valium' or whatever you want to call it for essentially trivial reasons. That is what I failed to forsee in 1947, when I wrote *Nineteen Eighty-Four*. At that time, I was pre-occupied with the Christian vision of remaking society by remaking man, and the Marxist vision of remaking man by remaking society; it never occurred to me that man on his own would, given the opportunity, choose to remake himself by way of a vastly expanded pharmacopeia, both legal and illegal.

WH: I take it then, that if you were to write *Nineteen Eighty-Four* again, you would do it differently.

EAB: No, I'm not saying that. If I were to make any changes, I think it would be to that other political allegory of mine that has caught the fancy of the world.

WH: You mean *Animal Farm*?

EAB: That's the one.

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Editor... Letters to the Editor... Letters to the Editor...

Harsh warning on herbs tarnishes health food industry

William T. Jarvis' attempt to anathemitize herbalism (Herb 'highs' potentially dangerous, **The Journal**, Nov 83) is at once curious and disturbing.

Does Dr Jarvis' diatribe herald the arrival of a McCarthy-like paranoia in his suggesting there is a "direct parallel" between drug pushers and health food store operators? Are we to believe herbs are offered to the general public for their "hallucinogenic, euphoric, or marijuana-like effects?"

As a user, grower, and seller of herbs for the past 14 years, I am aware of some abuses, and they are a concern to me. But I hardly feel that Dr Jarvis's quixotry is warranted here.

Some herbs, such as belladonna and stramonium, are indeed dangerous if misused. But most health food store operators and herbal practitioners would welcome restrictions on such herbs since they are relatively few in number and not generally offered for sale anyway.

As in any industry, there are those few who are irresponsible enough to allow greed to get the better of them. Need we, however, paint a picture of exploitation and cultism for the entire industry? Most industry members I know are deeply committed to standards of integrity and honesty not exceeded elsewhere in the health field.

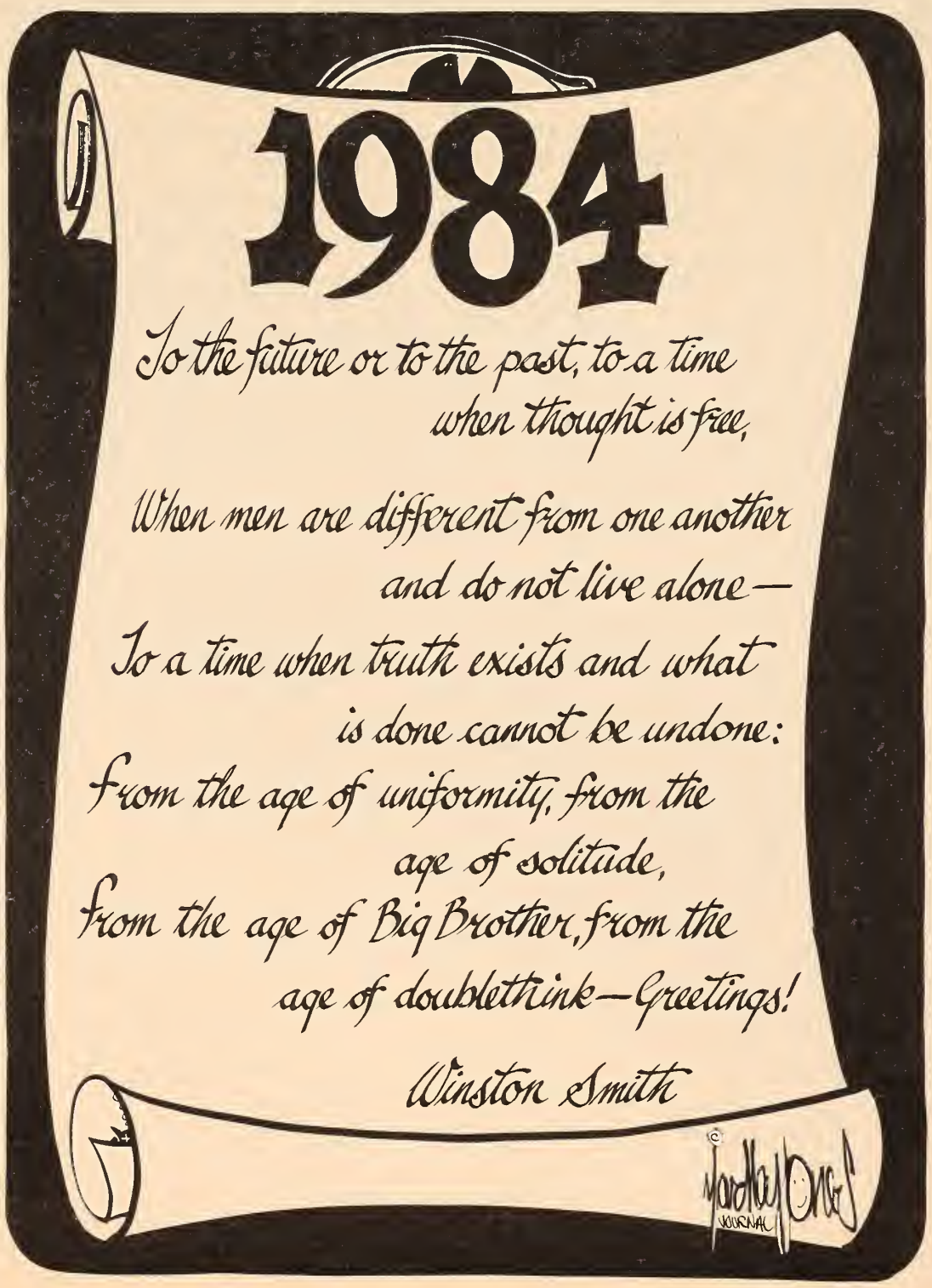
It is interesting that Dr Jarvis should cite examples of 15 pharmacologically-active herbs sold in health food outlets. Would he have it that only pharmacologically-*inactive* (ie useless) herbs be sold?

It is refreshing, though, to hear that ginseng is now considered by the learned to be "pharmacologically-active" after years of obstinacy on their part.

Perhaps Dr Jarvis would better appreciate herbs and the reason for their reappearance on the health care scene by examining the deficiencies of conventional medicine.

Conrad Richter
Richter's Herbs
Goodwood, Ont

The Journal welcomes Letters to the Editor. Letters bearing the full name and address of sender may be sent to: The Journal, 33 Russell St, Toronto, Canada M5S 2S1.



ILO approached

Aid sought for rehab

In **The Journal** (June 83), I read the article, Few nations are seeking help to develop drug rehabilitation programs.

We are very interested in having the address of the International Labour Organization (ILO) and of Ed Sackstein, the agency's drug rehabilitation specialist.*

Hogares CREA (Centre for the Re-education of Addicts), Inc is a non-profit organization whose main efforts and programs are aimed at the prevention, treatment, and rehabilitation of drug addicts and alcoholics.

We are very much in need of funds to continue offering services not only in Puerto Rico, but also in other countries where we have established Hogares CREA, such as the Dominican Republic, Venezuela, Costa Rica, and some (United States) states such as Pennsylvania, New Jersey, and New York.

Our funds are very limited since they are mainly donated by the community where the Hogar CREA agencies are established. So we are very interested in writing to the ILO to see if we can get help to continue carrying out our program for the rehabilitation of the people we have in treatment, especially during the re-entry period.

Juan Jose Garcia
President
Hogar CREA Incorporado
Saint Just
Puerto Rico

* *Vocational Rehabilitation Branch, Training Dept, ILO, 1211 Geneva 22, Switzerland.*

Drugs in workplace topical for health inspectors

I read with great interest, Harvey McConnell's article, Workers demanding to be protected from drug-using colleagues, which appeared in the November 1983 issue of **The Journal.**

This article will be of great interest to public health inspectors across Canada and abroad. *The Environmental Health Review* is the voice through which health inspectors, environmentalists, and other health care professionals are kept abreast of recent research, technical information, and other topical material.

The Environmental Health Review would like to reprint Mr McConnell's article in its entirety with appropriate credits.

Michael J. Hujwan, Certificate for Public Health Inspection, Canada
Editor
Environmental Health Review
Etobicoke, Ontario

Marijuana: Some Answers for Young People and Parents — a supplement —
AND
1984 Calendar — pull out

The Journal

Marijuana

Answers for Young People and Parents

Although much has been learned in recent years about cannabis and its effects on users, much remains to be learned. It is therefore important that research in this area continue throughout the world, and that new information be made available as quickly as possible to the legislators and the public.

Meanwhile, it is important that everyone have at least a basic knowledge of cannabis effects and cannabis law in order to discuss the issues intelligently. This supplement is designed to provide such information. It is particularly targeted to parents and teenagers.

The Addiction Research Foundation has reviewed the research findings to date and has concluded that cannabis use presents real risks to health. Therefore, the Foundation strongly advocates that cannabis not be used.

Introduction

Cannabis — which includes marijuana, hashish, and hashish oil — has been used by large numbers of people in many countries, even though its possession and sale are against the law in most parts of the world. However, the majority of North Americans who have tried cannabis have done so only occasionally. Those who use it give a number of reasons for doing so. Many say they are curious and want to find out what it is like. Others have taken it in order to be sociable or because their friends use it. A large number say they take it mainly because they enjoy the way cannabis makes them feel.

Let's look at some of the questions commonly asked about marijuana, hashish, and hashish oil. Some can be answered from scientific studies, but others are the subject of current research and cannot yet be fully answered. For example, we do not yet have enough evidence about some of the possible health effects. However, a lack of evidence at this time does not necessarily mean that we can assume no harmful effects. They may well exist, but further research is necessary before we can be certain.

Let's start with where cannabis comes from.

The Cannabis sativa plant

Marijuana, hashish, and hashish oil come from a tough, vigorous plant, *Cannabis sativa*, which grows in many areas of the world. Scientists refer to these three products collectively as cannabis or cannabis preparations. There are two main types of the *Cannabis sativa* plant, each used chiefly for different purposes. One type generally found growing wild in Canada produces a very good hemp fiber which has long been used for making rope. It produces a relatively small amount of a substance called tetrahydrocannabinol which is often referred to simply as THC. The second type of *Cannabis sativa* originated in hot climates although it can grow in Canada. It contains higher concentrations of THC, but its fiber is not as suitable for making rope. It is this second type which is commonly cultivated (although it also grows wild) for its THC content. THC is the substance that is largely responsible for the "high" that users seek from cannabis preparations.

Most of the THC in the cannabis plant is concentrated in its top, the flowers and upper leaves having the greatest amount. However, this plant has both male and female forms, and it is the sticky resin on the flowering top of the female plant which has the most THC.

Marijuana is made of the dried flowering tops and leaves. It often contains seeds and stems, as well. Hashish is the dried sticky resin and compressed flowers. Hashish oil is obtained by soaking hashish in alcohol or certain other solvents which are later evaporated. The potency of cannabis preparations (reflecting the amount of THC per unit of weight) is highly variable. Marijuana usually contains the least THC, and is therefore the least potent, while hashish oil contains the most THC and is the most potent. In general, the more potent cannabis products — hashish and hashish oil — have become increasingly available in Canada over the last several years, as have certain much more potent forms of marijuana.

Some dealers sell cannabis to which other substances have been deliberately added; usually this is done to increase the volume so as to make it appear that there is more of the drug than is really the case. Occasionally, other drugs are added. Sometimes, unknown to both buyers and dealers, cannabis contains potentially harmful bacteria, fungi, or chemicals intended to destroy plants, such as paraquat.

Who uses cannabis?

In 1982, a survey of Canadian students, ages 12-19, found that about 20% had tried cannabis at least once during the 12 months prior to the survey. However, the percentage of users varies from one province to another. In a 1983 survey of Ontario students (grades 7-13), approximately 24% reported at least some use of cannabis in the past year. In this survey, the highest rate of use was among 11th graders (approximately 42%). Boys of all ages were more likely than girls to have tried cannabis (28% and 19% respectively). (**The Journal**, January, page 2.)

While these figures are cause for concern, it should be emphasized that the majority of teens have never used cannabis. If young people were aware of this fact, they might find it easier to resist the peer pressure to experiment with cannabis.

What about adults? In the late 1970s, a nationwide survey found that approximately 17% of Canadian adults (ages 18 and older) *had used* cannabis in their lifetime, and most of those who said they had were under the age of 30. However, when adults were asked if they had used cannabis at anytime during the 12 months prior to the survey, less than 10% said "yes." In fact, less than 4% reported any use during the 30 days immediately prior to the survey. These figures for adults appear not to have changed greatly during the past few years. For example, a 1982 survey of Ontario adults found that less than 9% had used cannabis in the 12-month period immediately before the survey, and almost half of these users took cannabis less than once a month. These data were similar to those in a 1977 Ontario survey.

Do cannabis users also use other drugs?

Young cannabis users are more likely than non-users to consume alcohol and tobacco, and are much more likely than non-users to take other illicit drugs. There appears to be a particularly strong association between regular cannabis use and experience with other illicit drugs. By contrast, only a very small proportion of those young people who have *never* taken cannabis report any use of other illicit substances. It would appear that for many who use illicit drugs, regular cannabis use came first, although there is no evidence that the physical and

This material was reviewed and verified with respect to scientific content by a panel of scientists and information specialists at the Addiction Research Foundation.

Available in booklet form from: Marketing Services, Dept 896, Addiction Research Foundation, 33 Russell St, Toronto, Canada M5S 2S1. Prepaid 75¢ per copy.

ANSWERS: 1T, 2T, 3F, 4F, 5F, 6F, 7T, 8F, 9T, 10F, 11T, 12F, 13F, 14F, 15T, 16T, 17T, 18F, 19T, 20F.

psychological effects of cannabis are directly responsible for progressing to other illicit drugs.

Cannabis is the most widely available illegal drug in North America, and is therefore most likely to be the first such drug which a person will use. Because it is illegal, it must be obtained from personal contacts. As a result, the more regularly people smoke cannabis, the more likely they are to know a large number of users, and dealers, of cannabis and other illegal drugs. Also, since they have already broken the law by using cannabis, many are likely to be more receptive than non-users to invitations to try some other illegal drug.

What do the cannabis preparations look like? How are they used?

Marijuana is often called "grass," and it actually looks like dried, chopped grass or an herb such as oregano. Its color can range from greyish-green to greenish-brown. Sometimes its texture is very fine, but it can also be coarse, rather like tea leaves. Sometimes it also contains small twigs and seeds. Most often it is smoked in the form of hand-rolled cigarettes, frequently called "joints." Marijuana is also smoked in a pipe.

Hashish varies in color from light-brown to near-black and its consistency may be soft or hard. Users generally call it "hash." It is often mixed with tobacco and smoked. Like marijuana, it is sometimes baked in food, such as cookies or cakes, and eaten.

Hashish oil, as its name suggests, is a thick oily product, which ranges in color from yellow to nearly black. It is often referred to as "hash oil" or "honey oil." A very small amount of hashish oil will produce the typical cannabis "high." Thus, hashish oil may be spread onto the tip of an ordinary cigarette, or sometimes onto the papers used for handmade cigarettes, and then smoked.

What is the cannabis "high" like?

There are several important factors which affect a person's reaction to any drug that acts on the mind, feelings, and behavior. Such factors include the kind of drug, the amount of the drug taken, and the way in which it is taken. This last factor determines how quickly and how much of the drug gets to the brain. When cannabis preparations are smoked, the THC reaches the brain much more quickly than when it is eaten. This is because drugs which are inhaled get into the bloodstream faster than drugs which are swallowed, and it is the blood that carries the drug to the brain. Smoking also produces a higher level of THC in the brain and, as a result, more intense effects than when the same amount of cannabis is eaten (i.e. swallowed), but the duration of the effects is shorter.

Drugs which affect the mind, feelings, and behavior can produce somewhat different patterns of effects in different users. Also, the intensity of effects can differ from one person to another. This picture is made even more complex because the same user may take the same drug on different occasions and experience different effects.

Cannabis is a drug whose effects are particularly sensitive to such factors as personal characteristics of the users and the mood they are in at the time — and these can greatly affect users' reactions to this drug.

Some other important factors include past experience with cannabis and other drugs, the user's expectations and attitudes, general state of health, reasons for using cannabis, and companions, as well as whether the drug-taking situation is relaxing or stressful.

Another key factor is combination drug-taking, or the presence of other drugs in the body. The effects of cannabis can be intensified or otherwise changed by the presence of other drugs, including alcohol. Therefore, the risks from combining cannabis with other drugs can be far greater than the risks from using it alone.

Typical effects

Let's consider the typical effects of cannabis on normal adults, who are occasional users, when they smoke low to moderate amounts of this drug. (We'll define "low to moderate" as 5-10 puffs ["tokes"] from a single marijuana cigarette.)

Shortly after the first few puffs, most smokers become physically inactive and relaxed, and begin to feel less inhibited. They often become more outgoing and talkative and may laugh spontaneously, although some experience periods of quietness and reflection. They may feel that their senses have become keener, and relatively unimportant objects in the environment may take on new or special meaning. Perceptions of time and space may change, so that, for example, time may seem to pass very slowly and estimations of distance may become inaccurate. Attention span and the ability to concentrate may be reduced and the ability to remember things that just happened may be impaired. Also, the abilities to process information and to perform complex tasks are hindered.

Several physical effects which often occur include impaired balance when standing, more rapid heartbeat, reddening of the eyes, increased appetite (the "munchies"), dryness of the mouth and throat, and drowsiness.

Many users experience confusion or anxiety at one time or another. These effects are particularly common in new users, but also occur in regular users.

Many of these effects can interfere dangerously with the ability to drive or to use other complicated machinery. Engaging in athletic activities could prove hazardous. Further, the effects of cannabis make it very difficult both to study and to retain what is learned.

The effects are usually felt for two to three hours after cannabis smoking. However, a hangover effect, muscle incoordination, and drowsiness may last after the "high" has passed, making it risky to drive or engage in other potentially dangerous tasks for at least several hours — even if the user believes that he or she has recovered completely. Such effects may last for up to 24 hours if the drug is eaten.

Higher doses

Users may experience particularly unpleasant effects when using higher than usual doses of cannabis. (We'll consider higher doses as more than one marijuana cigarette on a single occasion.) Thinking and memory processes can be significantly impaired, as can the ability to perform relatively simple tasks and to exercise good judgment. Feelings of fear, anxiety, or even panic are not uncommon, nor is becoming suspicious of close friends. Some users may experience frightening hallucinations — imagined experiences which the individual believes to be real, such as hearing voices when no one is speaking or seeing things which are not really there. Finally, high doses of cannabis can severely interfere with the perception of time and space.

Even otherwise normal people may experience any or all of these disturbing effects if sufficiently high doses of cannabis have been used. However, because the effects of smoked cannabis are so rapidly felt, experienced users are normally able to discontinue their intake before they begin to feel too uncomfortable. When these harmful effects do occur, they usually wear off within a few hours after the last puff. By contrast, when cannabis is eaten, users have less control over effects, and the effects tend to last much longer.

We considered, above, the typical effects of cannabis on normal individuals. However, some cannabis smokers may experience virtually all of the higher dose effects even when they take low doses. For example, people with serious emotional problems are much more likely to experience disturbing effects after using cannabis than are those who are emotionally healthy.

Can a person be seriously harmed by using cannabis only once?

The main danger posed by a single dose of cannabis arises from its harmful effects on behavior and mental functioning. This is particularly so in regard to skills essential to the safe operation of a motor vehicle or other potentially hazardous machinery. Cannabis interferes with judgment, muscle coordination, ability to estimate distance, attention span, and ability to concentrate and process information. Interference with *any* of these functions can result in an accident, and there is some evidence linking cannabis to fatal accidents.

Teenagers and parents should be aware that the risk of an accident can be even greater when someone uses cannabis in combination with alcohol or other drugs and then attempts to operate a motor vehicle or potentially hazardous machinery.

A small percentage of people suffer extremely unpleasant feelings, such as severe anxiety or panic, after using cannabis, and they may also experience hallucinations and feel highly suspicious of others. These effects are rarely lasting.

The likelihood of death resulting from an overdose of cannabis alone is extremely small.

What about the health effects of regular cannabis use?

As we look at the adverse health effects of regular marijuana use under the various headings such as the respiratory system, etc., it is extremely important for teenagers and their parents to know that the experimental research studies on humans, that form much of the basis for the information that follows, have involved only adults, mainly healthy young men. Consequently, there is reason to be concerned that cannabis may pose serious health risks — that are not yet understood — for teenagers in their critical maturational years.

Furthermore, as is the case with tobacco, there is likely to be a relationship between the extent of the health effects and the amount of marijuana smoked, as well as the duration and frequency of its use. In other words, with cannabis, as with other drugs, the risk to health increases with increasing doses and length of exposure.

We cannot say that there is a safe level of intake.

Respiratory system

Perhaps the area of greatest agreement among researchers concerns the damaging effects of inhaled cannabis smoke on the respiratory system. A single marijuana cigarette yields twice as much tar as a strong tobacco cigarette, and cannabis tar contains substantially higher amounts of some known cancer-producing agents than does tobacco tar. Keep in mind also that many cannabis smokers have developed a style of smoking which can greatly increase the risk of serious lung damage: they inhale deeply and try to retain the smoke in the lungs longer than tobacco smokers usually do in order to permit the maximum absorption of THC. Moreover, cannabis users tend to smoke as much of the cigarette as they can, usually leaving almost none of the cannabis unsmoked.

Since cannabis users are more likely than non-users to be tobacco smokers, those who are regular smokers of both cannabis and tobacco are at particularly high risk.

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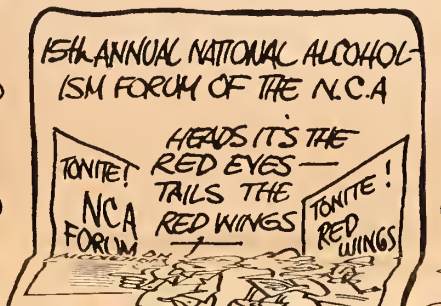
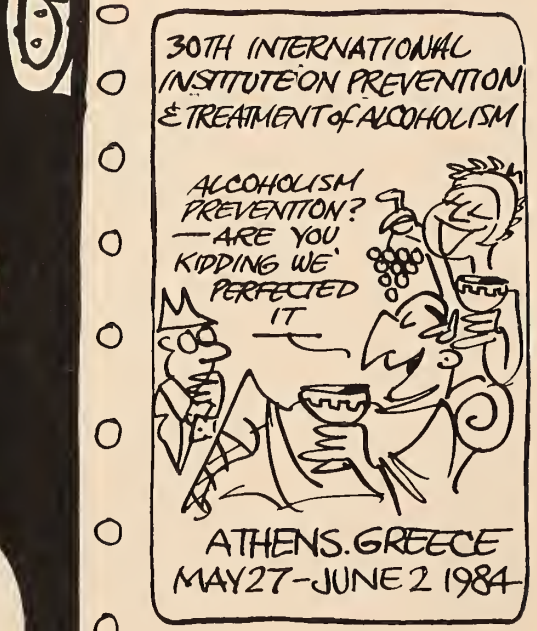
1984

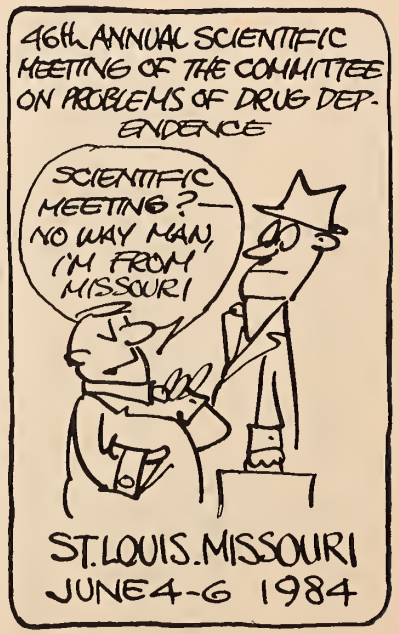
The Journal

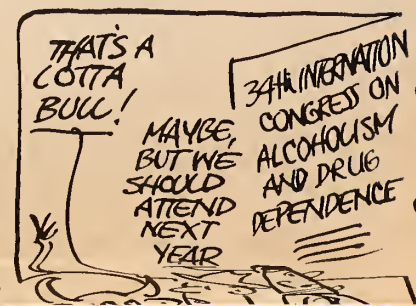
CALENDAR

1984









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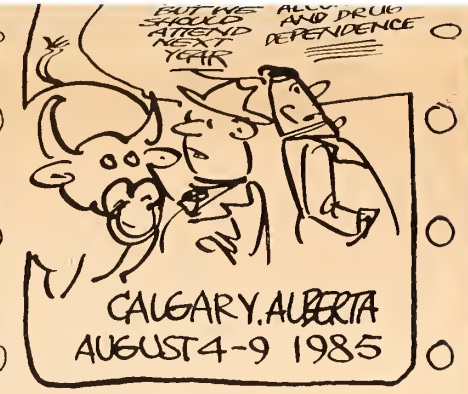

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The Journal

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DEPARTMENT

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Group Therapy Course — Jan 9-13, Toronto, Ontario. Information: Doreen Ross, Addiction Research Foundation (ARF), School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

"A Challenge: Service Delivery to Immigrants, Specifically the Chinese and South-East Asians" — Jan 14, Toronto, Ontario. Information: Dr Peter Chang, Whitby Psychiatric Hospital, Box 613, Whitby, ON L1N 5S9.

Fundamental Concepts Course in Addictions — Jan 16-19, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Perspectives on Employee Assistance Programming Course — Jan 23-26, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Annual Meeting of the Ontario Psychiatric Association — Jan 26-28, Toronto, Ontario. Information: Donna Gray, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

The Canadian Society of Hospital Pharmacists 15th Annual Professional Practice Conference — Feb 6-8, Toronto, Ontario. Information: Canadian Society of Hospital Pharmacists, Ste 303, 123 Edward St, Toronto, ON M5G 1E2.

Pharmacology and Drug Abuse Course — Feb 6-8, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Drug Information Symposium — Feb 9-10, Toronto, Ontario. Information: Canadian Society of Hospital Pharmacists, Ste 303, 123 Edward St, Toronto, ON M5G 1E2.

37th Annual Convention of the Ontario Psychological Association — Feb 9-11, Toronto, Ontario. Information: Dr Pierre Ritchie, Convenor, OPA '84, 1407 Yonge St, Ste 402, Toronto, ON M4T 1Y7.

National Joint Conference on Nursing Education and Practice — Feb 9-12, Ottawa, Ontario. Information: Jocelyne Robert-Tanguay, Conference Coordinator, Canadian Nurses Association, 50 The Driveway, Ottawa, ON K2P 1E2.

Prevention Strategies Workshop — Feb 20-22, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Workshops 1983-84: Employee Assistance Program Management Update — Feb 22-24, Toronto, Ontario. Information: Yvonne Johns, department head, department of Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Relaxation and Stress Management Workshop — March 1-2, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Toughlove Weekend Workshop for Parents and Professionals — March 3-4, Vancouver, British Columbia. Information: Susan Wachtel, Community Service Foundation, PO Box 70, Sellersville, Pennsylvania 18960.

Detox Training Program — March 5-9, April 30-May 4, Toronto, Ontario. Information: Diane Hobbs, Coordinator of Detox and Rehabilitation Programs, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

Circuit and Rural Court Justice in the North — March 11-16, Yellowknife, Northwest Territories. Information: The Northern Conference, c/o Continuing Studies, Simon Fraser University, Burnaby, British Columbia V5A 1S6.

1984 Canadian Addictions Foundation Atlantic Regional Conference, Families and Drug Dependencies New Problems, New Challenges — April 29-May 3, Halifax, Nova Scotia. Information: Nova Scotia Commission on Drug Dependency, 5668 South St, Halifax, NS B3J 1A6.

North American Society of Adlerian Psychology and "NASAP '84" — May 25-29, Toronto, Ontario. Information: Katy Anderson, Publicity Director, Alfred Adler Institute of Ontario, 4 Finch Ave W, Ste 10, Willowdale, ON M2N 2G5.

Summer Fundamental Concepts Course — July 16-19, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

1984 Annual Convention of the American Psychological Association — Aug 24-28, Toronto, Ontario. Information: American Psychological Association, 1200 17th St, NW, Washington, DC 20036.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-9, 1985, Calgary, Alberta. Information: Jan Skirrow, Chairman, 34th ICAA Congress, AADAC, 6th fl, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

United States

Chemical Dependency: Children's Issues — Jan 18, **Children's Programming**, Jan 19-20, Milwaukee, Wisconsin. Information: Candee Brandis, Training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

Alcoholism — The Search for the Sources — Jan 18-20, Charlotte, North Carolina. Information: Myra A. Carpenter, Alcoholism Research Authority, Wing B Medical School 207-H, Chapel Hill, NC 27514.

Update and Training Workshop on Alcoholism Clinical and Treatment Planning Requirements of the Joint Commission on Accreditation of Hospitals — Jan 19-20, Orlando, Florida. Information: Michael Q. Ford, Executive Director, NAATP, 2082 Michelson Dr, Ste 200, Irvine, California 92715.

Student Assistance Program —Jan 23-27, Milwaukee, Wisconsin. Information: Candee Brandis, Training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

5th Training Institute on Addictions — Feb 2-7, Clearwater Beach, Florida. Information: The Institute for Integral Development, PO Box 2172-T, Colorado Springs, CO 80901.

10th Annual Advanced Winter Workshop, Treatment and Rehabilitation of the Alcoholic — Feb 5-10, Colorado Springs, Colorado. Information: Psychotherapy Associates, PC, 3208 N Academy Blvd, Ste 160, Colorado Springs, CO 80907.

Toughlove Weekend Workshop for Parents and Professionals — Feb 11-12, Santa Clara, California. Information: Susan Wachtel, Community Service Foundation, PO Box 70, Sellersville, Pennsylvania 18960.

Toughlove Weekend Workshop for Parents and Professionals — Feb 18-19, Anaheim, California. Information: Susan Wachtel, Community Service Foundation, PO Box 70, Sellersville, Pennsylvania 18960.

Pharmacology and Drug Dependence — Feb 27-28, Indianapolis, Indiana. Information: Kay F. Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

International PRIDE Conference for Adults and Youth — March 22-24, Atlanta, Georgia. Information: PRIDE, 100 Edgewood Ave, Ste 1216, Atlanta, GA 30303.

Health and Addictions Seminar — March 25-30, Park City, Utah. Information: The Institute for Integral Development, PO Box 2172-T, Colorado Springs, Colorado 80901.

Ruth Fox Course for Physicians — April 12, Detroit, Michigan. Information: Claire Osman, Course Coordinator, American Medical Society on Alcoholism, 733 3rd Ave, New York, NY 10017.

15th Annual Medical-Scientific Conference of the National Alcoholism Forum, "Clinical Applications of Alcoholism Research" — April 12-15, Detroit, Michigan. Information: Medical-Scientific Conference Coordinator, AMSA, 733 3rd Ave, 14th fl, New York, NY 10017.

National Alcoholism Forum of the National Council on Alcoholism — April 12-15, Detroit, Michigan. Information: Angela Masters, 733 3rd Ave, New York, NY 10017.

5th Regional Conference on Substance Abuse "Innovations in Prevention and Treatment" — April 18-20, Cincinnati, Ohio. Information: Ann Blankenhorn, Central Community Health Board, 532 Maxwell Ave, Cincinnati, OH 45219.

Introduction to Alcohol/Drug Counseling — April 25-27, Indianapolis, Indiana. Information: Kay F. Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

46th Annual Scientific Meeting of the Committee on Problems of Drug Dependence — June 4-6, St Louis, Missouri. Information: Dr Joseph Cochin, department of Pharmacology, Boston University, School of Medicine, 80 East Concord St, Boston, Massachusetts 02118.

2nd Congress of the International Society for Biomedical Research on Alcoholism — June 24-29, Santa Fe, New Mexico. Information: Richard A. Deitrich, department of Pharmacology, Alcohol Research Center, University of Colorado, Health Sciences Center, 4200 E 9th Ave, Denver, Colorado 80262.

Abroad

An International Conference on Alcoholism and Drug Addiction — April 2-7, Canterbury, England. Information: Conference Secretary, Broadway Lodge, Oldmixon Rd, Weston-super-Mare, Avon, BS24 9NN, England.

6th International Conference on Alcohol Related Problems — April 8-13, Liverpool, England. Information: Dr A. I. Morris, Chairman, Conference Organizing Committee, 1st Floor, Fruit Exchange, Victoria St, Liverpool L2 6QU, England.

30th International Institute on the Prevention and Treatment of Alcoholism — Athens, Greece, May 27-June 2. Information: International Council on Alcohol and Addictions, Case postale 140, 1001 Lausanne, Switzerland.

15th World Congress of Rehabilitation International — June 4-8, Lisbon, Portugal. Information: National Secretariat for Rehabilitation, International Fair of Lisbon, Praca das Industrias, 1399 Lisbon-Codex.

4th World Congress of Alternative Medicine — July 13-15, Amsterdam, Netherlands. Information: Dr Anton Jayasuriya, Secretary Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

3rd International Conference on Treatment of Addictive Behaviors — Aug 12-16, North Berwick (Edinburgh), Scotland. Information: William R. Miller, department of Psychology, University of New Mexico, Albuquerque, New Mexico 87131.

The International Congress on Alcohol Dependence, the Family, and the Community — Sept 17-22, Jerusalem, Israel. Information: Kenes-Organizers of Congresses and Special Events Ltd, PO Box 50006, Tel Aviv 61500, Israel.

11th International Conference of Social Gerontology — Oct 16-19, Rome, Italy. Information: International Center of Social Gerontology, 91, rue Jouffroy, 75017 Paris, France.

2nd Inter-American Symposium on Health Education — Nov 4-9, Acapulco, Mexico. Information: Symposium Steering Committee, c/o NARO, PO Box 2305, Station D, Ottawa, Ontario, K1P 5K0.

12th International Conference on Health Education — Sept 1-6, 1985, Dublin, Ireland. Information: Dr H. D. Crawley, Director, Health Education Bureau, 34 Upper Mount St, Dublin, Ireland.

Regular cannabis smoking, like tobacco use, is associated with such chronic (that is, long-term) respiratory tract conditions as bronchitis, asthma, sore throat, and inflammation of the sensitive linings of the nasal passages. Preliminary evidence suggests that smoking several "joints" per day could contribute to lung cancer.

Personality and behavior

There has been a great deal of interest in the effects of regular cannabis use on personality and behavior. However, the research findings are not consistent and are difficult to interpret. Some researchers report that individuals who use high doses of cannabis regularly for a long time stop being contributing members of the family and community. They seem to no longer care about themselves or their surroundings; they show decreased ambition and loss of interest in the future. Some regular users do appear to experience these symptoms. However, it is unclear whether or not such problems are the result of cannabis use, or simply occur at the same time. When they do occur, such symptoms usually do not reflect a permanent change in personality, and they tend to disappear gradually when cannabis use is stopped.

The incidence of the above symptoms in regular users is not yet known. However, one recent (1981) nationwide survey of the graduating class of United States high school students provides evidence that the above and other behavioral symptoms may be more common than was previously thought. More than half (52%) of those 12th grade students who had stopped using cannabis after taking it frequently reported a loss of energy or ambition as one reason for their decision to quit.*

In the same survey, it was reported that many current daily users also felt their cannabis use caused a loss of energy (43%), as well as impaired school and/or work performance (34%) and decreased interest in other activities (37%). A number (37%) reported impairment of their ability to think clearly, although it is uncertain whether they meant for a few hours immediately after smoking or all of the time. Finally, 39% said that cannabis interfered with their relationship with their parents.

Several studies have also found that, on average, users, and in particular regular users, make lower grades in school than non-users and are absent more often.

Sometimes, more severely disruptive symptoms are observed in regular heavy users. Extreme suspiciousness of others and emotional depression have been reported in a few cases, although many more users become increasingly irritable, nervous, and short-tempered. These symptoms also tend to clear gradually after cannabis use is terminated.

Many professionals have expressed concern over the potentially harmful effect of regular use on the developing personality of teenagers, particularly younger teenagers, because this is a period of such rapid and dramatic change. In our society, adolescence is typically one of the most stressful periods of life, even for the most well-adjusted. During this important and lengthy stage of development young people learn (or fail to learn) how to cope adequately with unpleasant but common feelings such as anxiety and depression. If they regularly use drugs, including alcohol and cannabis, to avoid or to escape from normal stress, they may be depriving themselves of the opportunity to learn drug-free means of handling the everyday upsets of life. As adults, they are likely to continue to turn to drugs to deal with life's stresses.

Generally, the greater the amount of cannabis used, and the more frequently it is used, the more likely the danger of harmful psychological effects.

The brain

We simply do not yet have adequate information about the long-term harmful effects of regular cannabis use on the human brain. We do know, however, that certain important brain functions, such as memory and concentration, are often impaired in regular users and this undoubtedly affects their school performance. Nonetheless, this impairment in humans appears to be reversible, that is, it tends to clear gradually after cannabis use is stopped.

In a number of studies, rats have shown impaired learning ability (suggesting disruption of brain functioning) lasting for many months after the end of a 3-6 month period of regular cannabis administration, although this is not proof that similar impairment develops in humans. More research is necessary in this important area.

Sexual functions

Another important area of current investigation is on the effects of cannabis on the reproductive functions. Many people think of cannabis as an aphrodisiac — they believe that cannabis stimulates sexual feelings. Actually, cannabis does not appear to do this directly. Rather, like alcohol, it can reduce inhibitions. And when inhibitions are lowered, some people express sexual feelings more freely. However, such openness in feelings does not occur in all cannabis users. In fact, some regular users experience a reduced interest in sex.

Our knowledge of the effects of regular cannabis use on human reproductive systems is currently very limited. Some researchers have reported changes in hormones in healthy adults. A few, but not all, studies have found a reduced level of testosterone and a lowered sperm count in males who are heavy users, and there is preliminary evidence that cannabis smoking may interfere with the normal menstrual cycle in females. These changes do not appear to be lasting after cannabis use is stopped. However, we know very little about the impact of regular cannabis use on the normal sexual development of adolescents.

The effects of cannabis on the human fetus, resulting from the mother's use of the drug during pregnancy, are not yet clearly understood. Animal studies suggest, however, that exposure to cannabis, either before or after birth, may interfere with normal growth and development. Therefore, it is especially unwise for pregnant women and those attempting to become pregnant to use cannabis.

At this time, there is no evidence that cannabis smoking will have adverse effects on babies conceived after use has stopped.

Once again, it must be noted that a lack of evidence does not necessarily mean we can be certain that there are no harmful effects, as very little research has been done in this area.

Hostility

Does cannabis increase the likelihood of aggressive or hostile behavior in users? Generally, no. Unlike alcohol, cannabis is rarely implicated in violent conduct. Occasionally, users who are experiencing a negative reaction to cannabis behave in a hostile manner toward others, although they are far more likely to react with fearfulness.

Other effects

There is evidence in animals that cannabis use may interfere with some aspects of the body's immune system — the system that protects the body from disease. It is not yet known whether such an effect is likely to be significant in humans.

The cardiovascular system — the heart and blood vessels — of healthy individuals does not appear to be permanently affected by cannabis use. However, since cannabis increases the heart rate, it is reasonable to expect that the use of cannabis may be particularly harmful to those with heart disease.

Tolerance

Users experience a reduced effect when they use certain drugs frequently. This phenomenon is called tolerance. When tolerance develops, larger amounts of the drug must be taken in order to experience the same degree of desired effect as was felt initially.

Frequently, cannabis use results in the development of some degree of tolerance to the desired effects. As a result, there is a tendency to increase the amount of drug used at one time. Of course, higher amounts taken regularly result in an increased risk of harmful effects, particularly on the respiratory system and on certain mental functions, such as memory and concentration.

Can you become dependent on cannabis?

The issue of whether or not regular cannabis use can result in dependence on the drug is not yet fully resolved. Part of the problem is that different scientists mean different things when they discuss dependence. Many believe that there are two distinct types of dependence: physical dependence and psychological dependence. Other scientists do not accept such a distinction. Nonetheless, for our purposes, we will consider both physical and psychological dependence on cannabis.

Physical dependence occurs when the body gradually changes the way it functions in the presence of a drug. The "normal" state of the body then occurs only when the drug is present. When it is absent, unpleasant symptoms are experienced. These symptoms are collectively referred to as a "withdrawal reaction."

Some people who use high doses of cannabis several times daily do acquire a mild form of physical dependence on it. When they abruptly stop using cannabis, they may experience mild symptoms such as irritability, nervousness, sleep disturbances, loss of appetite, sweating, and upset stomach.

People can become *psychologically dependent* on a wide variety of drugs, including cannabis, no matter what dose is regularly used. The psychologically dependent user has a strong need to continue taking the drug, a persistent craving for its effects, and considers the drug to be a necessary part of daily life. Anxiety (and even feelings of panic) may result if the drug is not available. People can be compulsive users of cannabis (that is, psychologically dependent on cannabis) without being physically dependent on it.

It is difficult to estimate the number of users who become dependent on cannabis. Some experts believe that the percentage is fairly small. Nevertheless, even a small percentage represents a substantial number, given the overall number of cannabis users in our society. Certainly, there are more young people seeking professional help for cannabis dependence, and it seems likely that this trend will continue. Data on recent cannabis-involved admissions to federally funded drug treatment services in the U.S. provide a striking example of this last point. In 1981, more than 35,000 *different* patients** admitted for treatment of drug problems reported their primary drug of abuse to be cannabis, while in 1978 the figure was somewhat more than 23,000 — an increase of approximately 50% in three years. More than half of ali these admissions were 19 or younger, in spite of evidence that there has been no comparable increase in cannabis use among young people during these years.

Are the legal penalties serious for cannabis possession?

Many people believe that a first offence for possession of small amounts of cannabis for personal use merely results in a legal "slap on the wrist." Even if tried by way of summary conviction, a first-time cannabis

*In this survey, frequent users were defined as those who used cannabis 40 or more times in their life.
**Some were admitted more than once in the same year.

possession offender may be fined up to $1,000 and/or imprisoned for up to six months. If the prosecutor decides to proceed by way of indictment, the maximum penalty for a first offence is seven years' imprisonment. It is true that first offenders are routinely tried by way of summary conviction and that the vast majority receive fines, suspended sentences, conditional discharges, or absolute discharges. While relatively few cannabis offenders are sentenced to a term of imprisonment, there are a number of adverse consequences that flow from being a criminal offender, perhaps the most significant of which is what is commonly known as a federal criminal record.

Although the law does not provide a definition of the term "criminal record," it is generally used to refer to a plea of guilty or a finding of guilt for any federal criminal offence. Contrary to what is often said in the media, even those who receive a discharge or those who subsequently apply for and receive a pardon have a criminal record. Both pardons and discharges provide some limited legal benefits to those who receive them. Nevertheless, discharged and pardoned offenders cannot honestly deny having a criminal record. A criminal record may impede the offender's ability to travel abroad, to acquire Canadian citizenship, to enter certain professions and occupations, to work for the government, or to get even menial jobs. Moreover, an individual with a criminal record is at a distinct disadvantage in any subsequent criminal proceedings.

What about the penalties for selling or growing cannabis?

The maximum penalty for importing, exporting, trafficking, and possession for the purpose of trafficking is life imprisonment. The term "trafficking" is broadly defined to include not only selling, but also transporting, and giving or sharing drugs with another person. The cultivation (or growing) of cannabis, as with these other crimes, is an indictable offence but it carries a maximum sentence of seven years' imprisonment. An individual may be convicted of any of these offences, even if the quantity of cannabis involved is relatively small. As in the case of cannabis possession, the sentences actually imposed for importing, exporting, trafficking, possession for the purpose of trafficking, and cultivation are, with few exceptions, much lower than the maximum penalties.

However, a jail term of at least seven years *must* be imposed for importing or exporting. Even if a jail term or substantial fine is not imposed for these other crimes, the offender may suffer many of the adverse consequences of having a criminal record for an indictable offence.

What is the Addiction Research Foundation's position on cannabis use?

The Foundation has carefully reviewed the research findings available to date and has concluded that cannabis use presents real risks to health. Therefore, the Foundation advocates strongly that cannabis not be used.

Although much has been learned in recent years about cannabis and its effects on users, much remains to be learned. It is therefore important that research in this area continue throughout the world, and that new information be made available as quickly as possible to the legislators and the public.

What should I do if I find out my teenager is using cannabis?

How you approach your teenager is really important. As hard as it may be, try to remain calm. Get the facts about cannabis. Much of the basic information is contained in this supplement, so you may wish to read it a second time. As well, ask yourself the following question: "Can I discuss my concerns with my teenager without ending up in a shouting match?" If you can't honestly answer "yes" then you might wish to seek advice before deciding upon the best course of action. Possible sources of good advice in your community may include your local Addiction Research Foundation office, your physician, clergyman, pharmacist, public health unit, or a professional in the drug abuse field.

If there is another parent in the household, it is important that you achieve an understanding as to how you will handle the situation together. The chances of a good result can be increased if you and your spouse agree on how to approach your teenager and what the expectations should be.

In discussions with your teenager it is very important that you assume the role of concerned and loving parent as well as the role of disciplinarian. Indicate your reasons for suspecting that marijuana is being used and provide an opportunity for the teenager to respond. If it seems clear that your concerns are justified, explore how long the drug use has been going on, and under what circumstances it started. Listen carefully to what your teenager says. Try to encourage an open and honest discussion. State clearly to your teenager how you feel about drug use, and that you want to help and to understand.

What should I do if I think I'm having problems because of cannabis?

Perhaps you've decided to quit but aren't sure how to go about it. Many young people stop on their own simply by making up their minds and then following a few basic rules they set for themselves.

Most importantly, they make sure they avoid the situations in which they have most often used cannabis. This usually means certain people or particular places. They also plan other things to keep themselves busy so if someone asks them to smoke marijuana they have a ready-made reason to say "no." Often, they think about what others might say to try to talk them into using cannabis, and they rehearse answers in their minds or out loud to help them avoid the pressure.

For some, stopping on their own is too difficult, especially if they have been using a lot or for a long time. If you're one of these people, maybe you should seek some help. Not that anyone else can make the decision for you, but sometimes knowing someone is there to back you up or to test your ideas gives you the little extra it takes.

If you are going to talk to someone, it's important to choose a person you have confidence in and can trust. If you think you can talk to your parents, this usually is the most ideal situation. Remember, your parents may be initially upset, but the important thing is to be able to tell them and give them a chance to help. It will make it easier if you choose a time and place without distractions and start out by saying something like, "I have a problem and I need some help."

If talking to your parents is likely to end up in an argument or a shouting match, then maybe you should try someone else. Other possibilities are an older brother or sister, a favorite relative, a guidance counselor, a special friend, or a family doctor. It may be that you'd feel more comfortable talking to a trained counselor. If so, contact the Addiction Research Foundation or a youth counseling service in your community. Youth counseling services are frequently listed under "Social Service Organizations" in the Yellow Pages.

It is very common for people using drugs to have mixed feelings about their drug use. On the one hand they enjoy the effects of the drugs, but on the other hand they recognize the possible serious consequences. If you're uncertain about what you want to do, first make sure you know the facts. Read this supplement carefully and obtain additional information if you think it's necessary. Remember, too, you don't have to make up your mind to stop in order to talk to a drug or youth counselor. Having someone to talk to can often help you decide what to do.

Test your knowledge

The following 20 statements will test your knowledge concerning cannabis. Answer true or false. Answers are at the bottom of page S1. In fact, the information has been fully explained in the text. For example, the answer to question one can be found in paragraph 7, page S1.

1. THC is largely responsible for the "high" one gets from marijuana, hashish, and hashish oil. ☐
2. Hashish oil usually contains the most THC. ☐
3. Marijuana is usually sold in the form of a very fine powder. ☐
4. The effects of cannabis are felt for a longer time when it is smoked than when it is eaten. ☐
5. Memory is not affected by cannabis. ☐
6. People never feel anxious or upset after having taken cannabis. ☐
7. Cannabis users are more likely than non-users to have tried other illicit drugs. ☐
8. The ability to drive is not affected by cannabis. ☐
9. High doses of cannabis can cause people to see things that are not there. ☐
10. Normal people never have a bad reaction to cannabis. ☐
11. Past experience with cannabis can affect how a person reacts to this drug. ☐
12. The effects of cannabis are the same regardless of whether or not other drugs are taken along with it. ☐
13. Cannabis yields less tar than tobacco. ☐
14. There is no evidence that cannabis smoking contributes to lung cancer. ☐
15. Regular cannabis use can cause people to become nervous and irritable. ☐
16. Regular cannabis use may interfere with normal personality development. ☐
17. Some regular cannabis users experience a reduced interest in sex. ☐
18. It is not possible to become dependent on cannabis. ☐
19. There are some young people who have become so dependent on cannabis that they need professional help. ☐
20. People can estimate distances just as well after having taken cannabis as they can at other times. ☐

NEWS AND COMMENT

Effort to stem drug tide being thwarted

OSLO — Stock-piling and continued over-production of opium by developing countries, and resistance to control of psychotropics by developed nations, are creating major obstacles to international efforts to reduce drug abuse, says the director of the Malaysian National Drug Research Centre.

Viz Navaratnam told the 13th International Institute on the Prevention and Treatment of Drug Dependence here that policies to support efforts to reduce the supply of both licit and illicit drugs are essential in international drug control strategies.

However, these attempts are being threatened by "the massive opium stocks that are being held by the licit growing countries, as well as their continued over-production."

Dr Navaratnam said it is imperative to reduce areas of production to basic levels and suggested future production be based on exact need and under international supervision.

At the same time, he said, nearly all psychotropic drugs are produced in developed nations and the "perceived resistance" to control by some of these nations has created "an atmosphere of suspicion which undoubtedly is affecting collaboration in the field of international drug control."

Dr Navaratnam said financial considerations play a central role in drug production whether by governments in licit growing areas in countries with low per capita income, or by manufacturers in industrialized countries.

He said as control will have economic and social consequences in both categories of producers, the issues must be examined objectively and a single approach taken to control of all the substances.

"It is imperative that all nations realize the global nature of the problems of drug abuse." No nation has developed an "immunity to drug abuse based on geographic, cultural, economic, or any other indices." Acceptance of this concept is essential if international drug control policies are to have a "significant impact."

GILBERT

Optimal alcohol use: II

By Richard Gilbert

This is the second of two columns in which I am returning to consideration of the preventive effects of alcohol use, which I last discussed in the spring of 1980. (It is also the fifth anniversary of the first of these columns.) I shall develop further the notion that there is an optimal average level of alcohol use in a society, and I shall suggest how this notion might be used to determine public policy about the control of alcoholic beverages.

Last month I outlined some recent evidence on how moderate alcohol use — an average of between one and three drinks a day — is associated with lower mortality than are higher levels of consumption or total abstinence.

I also mentioned recent work on the likely mechanism of this effect. Alcohol use elevates levels of high-density lipoprotein cholesterol, which is known to be an anti-atherogenic agent, ie, it prevents the accumulation of fatty material on the lining of the arteries. The result is protection against coronary heart disease, the major cause of death in North America and Europe. Counteracting this protective effect is the association between alcohol use and death from accidents of all kinds on the one hand and specific alcohol-caused diseases such as liver cirrhosis on the other, both of which appear to occur in rough proportion to the amount consumed. The net result is a U-shaped relation between alcohol consumption and death, the lowest mortality being among moderate drinkers.

In the earlier columns I reported some cursory estimates I had made of the numbers of deaths caused and deaths prevented by alcohol in Canada in 1974, and the numbers of deaths that would have been caused and prevented had consumption been higher or lower. I concluded that alcohol use had led to a net saving of 430 lives in that year — 1,670 deaths caused by alcohol and 2,100 deaths prevented by alcohol. Using various statistical manipulations, I demonstrated that there would have been a net benefit in terms of mortality of 1,410 lives had average consumption been one drink a day rather than the actual level of close to two, but a net cost of 500 deaths if average consumption had been three drinks a day.

Medical optimum

The above considerations point to the notion of an *optimal level of alcohol use*. If no alcohol is consumed, there is no cost or benefit derived from its use. Moderate consumption in the order of one drink a day appears to confer a clear net benefit in terms of mortality. Consumption of about two drinks a day, today's average, also confers a net benefit but a lesser one. Consumption of three or more drinks a day confers a net cost. Thus there appears to be a medically optimum level of alcohol use in the order of one drink a day at which mortality is lowest. (These consumption levels are technically averages for the Canadian adult population. Broadly speaking they apply also to individuals.)

Generally speaking, public policy-making about alcohol has consisted of governments striking a balance between health and temperance interests on the one hand and various economic interests, including their own, on the other. The most powerful actors are usually the manufacturers of alcoholic beverages. They pay lip service to the case for moderation — it can boost a corporate image — but their basic concerns are those of all other businesses: sales and profits.

In seeking to increase alcohol use, the manufacturers have two useful allies: bureaucrats and consumers. Treasury officials are most appreciative of the revenue generated by alcohol sales. They resist efforts to reduce income from this source. Alcohol users — the majority of adults — prefer their purchases to be as painless as possible. High prices and restricted availability do not make for contented consumers.

Temperance

The opposition to alcohol use should not be underestimated. At one extreme is the vestige of the temperance movement, still strong in parts of Canada, including some of the ward I represent on Toronto City Council, which is part of Ontario's only remaining dry area. Its leader, Bill Temple, continues at 85 years of age to be a formidable influence. Politicians of all stripes still treat him warily, remembering how he beat the premier of Ontario in the 1945 election.

The medical establishment, not known for abstemiousness, appears to preach near abstinence. Evidence concerning the medically beneficial effects of alcohol is most often ignored in discussions about the prevention of problems caused by excessive use. For example, a recent publication from the World Health Organization's European Office entitled *Alcohol-related medicosocial problems and their prevention* appears to argue that *all* alcohol use is harmful. Its conclusion is that per capita consumption should be reduced, presumably to zero although the target is not stated.

(Not all physicians preach abstinence. Some belong to the Society of Medical Friends of Wine and Wine Institute, based in San Francisco. This organization collaborated with the University of California to hold a symposium in November 1981 on Wine, Health, and Society. The resulting volume includes an article by Arthur Klatsky — "A ten-year study of alcoholic beverages and cardiovascular mortality" — that I should have mentioned in last month's review of this topic. Klatsky reviewed health examination records for some 88,000 patients at Kaiser-Permanente Health Centers in Oakland and San Francisco. He concluded ". . . heavy drinkers are subject to a higher mortality rate, and . . . light drinkers have a lower mortality than non-drinkers, especially with respect to coronary disease.")

The result of the balance struck by governments, including the governments of Canada and Ontario, has mostly been a progressive decline in the real price of alcoholic beverages, an even sharper decline in their cost as a proportion of disposable income, and a progressive increase in opportunities to purchase alcoholic beverages. As a consequence, alcohol consumption rose dramatically until the mid-1970s. Since then, the price of alcohol has kept pace with inflation and mean disposable income. Opportunities to drink have increased, mostly in newly licensed eating places, but, as I explained in my April 1979 column, drinking out has been associated historically with moderation —probably because it costs more than drinking at home. Per capita alcohol consumption in Ontario and in Canada has changed little since 1974. Indeed, in Ontario, per capita consumption of alcohol in the form of alcoholic beverages has actually *declined* each year since 1978.

Arbitration

Governments like being in the middle. Arbitrating between strongly opposed interests is often easier than having a position yourself. A government that simply arbitrates can justify almost anything it does in terms of the arguments of one side or the other. A government that has its own policy suffers the burden of expected consistency.

A government that merely arbitrates can be all things to all interests. The health minister can preach abstinence while the finance and industry ministers argue for a healthy liquor business. The result is a balance that reflects the current strengths of the competing camps, rather than public opinion or what might be best for society. The chief victim of policy-making by arbitration is concern for what might be the optimal level of alcohol consumption.

I would like to propose a rational approach to making policies about the consumption of alcohol. It is to determine the average level of consumption that produces the maximum net benefit to society in terms of mortality, and then, by means of taxation, to steer society toward this average level.

In the case of Canada, my estimates made three years ago suggest that this optimal average level of alcohol use would be in the order of one drink a day, about half the current level. This determination of the optimum seems to be the only one that has been made. Because it has not been contradicted, I shall continue for the moment with the assumption that it is valid. A government setting policy according the notion of optimal alcohol use would be wise to commission a new and better estimate.

Ideally, government would be able to order consumption so that almost all adults consume an average of one drink a day (pregnant women might be an exception). In reality, consumption of alcohol in a large population will always vary enormously according to a log-normal distribution, as does use of other widely consumed products. This kind of distribution has a peak at a relatively low level of consumption and then a long tail into high and very high levels. What this means is that government can act only to shift the whole distribution, so that everyone drinks more or everyone drinks less.

Nevertheless, policy-makers are tempted to argue that the focus of control efforts should be upon excessive users, because they are the main part of the problem, and because moderate users should not be subjected to measures designed to reduce excessive use. The logistics of identifying and controlling alcohol use by excessive users should be enough to deter such arguments. There are about 300,000 adults in Ontario who consume an average of more than seven drinks a day. It would be impossible to identify and control the behavior of more than a very small fraction of these drinkers.

There are basically three ways in which government can influence average alcohol use — education, availability, and price. Education seems ineffective as a means of altering overall consumption levels. Restricting availability works in some cases and not in others: generally its effect is imprecise and often unexpected. Only manipulation of price through taxation affords a sure way of regulating alcoholic consumption.

Evidence as to the way in which alcohol use varies with price is more muddled than that for tobacco use, which I discussed here in April, 1982. The chief problem is the variety of forms of alcohol consumption, and the tendency of governments to have different taxation policies with respect to different forms. Nevertheless, it is reasonable to conclude that consumption is sensitive to price, and that raising taxes will lower the average level of alcohol use in a population, as common sense would suggest.

Just how much alcohol use declines with each unit increase in real price is far from clear. The best evidence for Canada suggests that an overall 10% increase in real price would produce a little less than a 10% reduction in average consumption, with perhaps a greater reduction in the use of liquor than in the use of beer. (The effect of price changes on wine use seems presently indeterminable; because relatively little wine is consumed, it is of little consequence.) Thus, a reduction by 50% might be achieved by imposing tax increases that would raise prices by a little more than 50%.

Sophisticated advice

An important question about the effect of price increases on alcohol use concerns the extent to which consumers of different amounts are differentially affected. It is often argued that heavy drinkers are much less sensitive to price changes.

A recent study by R.E. Kendall and colleagues reported in the *British Medical Journal* in September indicates that consumption at all levels is reduced by a similar proportion. Real price increases in alcoholic beverages in Britain between 1978 and 1981 amounted to some 5%, largely on account of large increases in tax, particularly on beer, in March 1981. Average consumption by 460 "regular drinkers" in the Lothian region of Scotland was found to fall by 18%, with consumption by the heaviest drinkers falling by 15%. (The per capita decline in alcohol consumption in Britain during this period was considerably less: teetotalers and occasional drinkers were under-represented in the group that was studied.) Reported adverse effects of alcohol use, including involvement in road accidents, fell by a similar amount overall, but with larger proportional changes among heavier drinkers.

This study to some extent resolves the question as to how heavy drinkers are affected by price increases — just about as much as lighter drinkers in terms of consumption and more in terms of reducing adverse effects.

The president of Ontario's Addiction Research Foundation, Dr Joan Marshman, began 1982 with a statement that the ARF should reconsider its belief in "the unqualified desirability of reducing per capita consumption" of alcohol and develop "more sophisticated advice" to government that takes into account the protective effects of alcohol against cardiovascular disease. A position based on achieving optimal alcohol use could form the basis of that kind of advice.

NEWS

Compulsive gambling . . . may spark endorphins

LAWRENCEVILLE, NJ — The compulsive gambler in search of "the action" may actually be looking for ways to increase the level of endorphins in his brain, Harvey Strassman, MD, told the 1st Statewide Conference of the Council on Compulsive Gambling of New Jersey here.

Dr Strassman, a professor of psychiatry at the University of Medicine and Dentistry of New Jersey, admitted the concept is still highly theoretical but noted it is one area that will be studied in a new research program on compulsive gambling begun with a $70,000 grant from the State of New Jersey.

An endorphin mechanism might explain the escalation of amounts gambled that defines the compulsive gambler, he said.

Lynn Payer reports from two United States conferences examining the problem of compulsive gambling

"One word that we keep hearing over and over again that people don't pay any attention to is 'the action,' " Dr Strassman said. "There is an anticipatory pleasure that something good is going to happen. There is the buildup of tension, then the release of tension. Soon there is not as much pleasure, so the gambler has to escalate the amount. One way is to increase the action so it's all the time; the other is the constant escalation in the amount of risk in order to get more pleasure out of it."

Although Dr Strassman said he was unaware of withdrawal symptoms in compulsive gamblers, another speaker, Robert L. Custer, MD, chief of Treatment Services and Mental Health, Central Office, Veterans Administration, in Washington DC, said there are very significant withdrawal symptoms in compulsive gamblers.

Dr Strassman also said the gambling industry uses a number of psychologic theories including operant conditioning and positive reinforcement. "The name of the game is action, and action is lights and noise and people being excited." When people hear the money hitting the trays, they know money is being won, he said.

The absence of clocks in gambling clubs creates a sense of timlessness, and chips, rather than real money, are gambled.

. . . reacts well to treatment

LAWRENCEVILLE, NJ — Compulsive gambling is a highly treatable disease, and the treatment is highly cost-effective, Julian I. Taber, PhD, chief of Pathological Gambling Treatment Services, Veterans Center, Brecksville, Ohio, said here.

Fifty-five percent of compulsive gamblers responding to a follow-up questionnaire had not gambled within one year, Dr Taber said.

Within one year, he said, most of the men who pay taxes will have covered the cost of treatment. "Of all VA (Veterans Administration) programs, this is the most cost-effective."

Dr Taber said an alcohol treatment centre provides an excellent model for the treatment of compulsive gamblers. About 45% of the gambling patients are recovering alcoholics or actual alcoholics and gamblers live in the same quarters, go to the same meetings, and see the same films as the alcoholics. However, gamblers do share rooms with other gamblers, he said.

In addition to cross-addictions, Dr Taber said gamblers often have other illnesses. Sixty-eight percent fit the criteria for depressive illness, although almost none are prescribed anti-depressants unless they show hard signs of depression, he said.

"Gamblers do commit suicide, often as a matter of expediency. They see it as a way to take care of their wife," for example, he said.

Compulsive gamblers also tend to be hyperactive, and about 30% fit the criteria for manic or hypomanic disorder. "Many of these clients will benefit from lithium therapy," he said, although patients resist the drug because they believe it slows them down.

Gamblers Anonymous (GA) and Gam-Anon are important elements of the treatment program, he said. Of those patients not gambling a year after treatment, 70% were found to be using aftercare and GA.

Dr Taber offered 10 rules for the treatment of the compulsive gambler:

1. Treatment is always an illusion. The therapist is powerless over this man's gambling problem. Only when the therapist admits that can he help the gambler find his own strength.
2. Faith in the treatment is the only cure. If the patient does not believe in the treatment, it will not work.
3. The gambler's family may be sicker than the gambler himself.
4. Self-help groups need a lot of help. Meetings may be too long and contain too many members who smoke too much, eat too much, and tear each other up.
5. Something else is always wrong — if not cross-addiction, then some psychiatric disorder.
6. Addictions never occur alone, and one addiction facilitates another.
7. One abstinence fosters another.
8. Gamblers never talk about what they most need to discuss and are least likely to do what they most need to do.
9. Gamblers always seek treatment for the wrong reason.
10. Relapse is the most important teacher. Statistics indicate the patient will relapse.

. . . and heavy drinking teamed in care plan

AMITYVILLE, NY — The interaction between alcoholics and compulsive gamblers in the same treatment program can be effective, says the treatment team at South Oaks Hospital here.

"A pure compulsive gambler cannot understand how alcoholics can drink to the point of destruction, where they fall down in the street, and can confront that type of denial because he cannot really understand it," explained Robert Cahill, coordinator of patient care for the alcoholism and compulsive gambling programs South Oaks Hospital.

"He can see the fantasy, the thought processes that are at work that are destructive. At the same time, the alcoholic cannot understand why the compulsive gambler will spend as much as he does," Mr Cahill told the 2nd annual Forum on Compulsive Gambling and Its Effect on Industry.

Richard Zoppa, MD, medical director of the compulsive gambling program said, "at the beginning we didn't know whether we could trust the gambler, so we thought of having a buddy system. So guess who we picked for their buddies — we picked alcoholics."

. . . inhibits alcohol recovery

LAWRENCEVILLE, NJ — Gambling can be dangerous for a recovering alcoholic, Rev Msgr Joseph A. Dunne, president of the United States National Council on Compulsive Gambling, said here.

Msgr Dunne said many recovering alcoholics don't realize that the high they feel from gambling is undermining their recovery as alcoholics.

"In a recovery program they must be warned that experimenting with gambling may be far worse than experimenting with alcohol," he said.

Money-tracking broadens scope of police

(from page 16)

ed by the RCMP, launched a program to trace and identify the money flow from illicit drug transactions. This program became operational in 1982 (**The Journal**, March 82). Specially trained investigators, with experience in both commercial crime and drug enforcement techniques, were selected to work on this program, and special units were established in every major Canadian city.

The investigations are already producing results. In addition to seizure of the funds linked to the drug transactions, many sophisticated laundering systems are being identified, including underground commercial systems in use for generations.

The evidence derived from these investigations has broadened the scope of criminal prosecutions in Canada through the identification of top members of the criminal organizations. These planners and organizers rarely come into contact with illicit drugs, but always arrange to receive the proceeds of illicit transactions. Tracing the proceeds, both within Canada and in foreign jurisdictions, is a vital first step to a financial investigation.

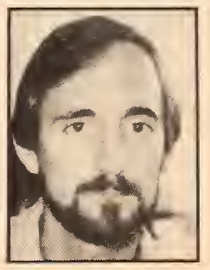
The evidence will serve two purposes: firstly, it may provide evidence of the original crime or a secondary crime connected with the movement of the funds; secondly, it may give rise to the seizure and forfeiture of the funds or assets themselves.

To fulfill only the first purpose requires a great deal of cooperation between the countries and jurisdictions through which the money laundering system operates. Only through positive interpretation of the laws, and a genuine desire by all enforcement officials who become involved, will positive results be achieved. This level of cooperation is not always forthcoming and can lead to a dead end, after a long and costly investigation.

The second objective may prove to be more difficult. By the very nature of a successful laundering scheme, the money from criminal activity is moved from place to place, from one jurisdiction, organization, or entity to another, changing in form until it is converted into an asset of value; it may be tangible or intangible personal property or real property. In the process, it may be combined with other funds, which originate from another illicit or licit enterprise. By the time the property is located, it may be an ongoing business entity, producing additional profits, employing many people, and owning many fixed assets.

Experience has shown that seizure and forfeiture or other punitive measures can be effected under existing laws if proof of the source of the funds is established.

Stamler



Fahlman

Therefore, the first stage of the financial investigation — tracing, identifying the money flows, and gathering evidence of the laundering scheme — is vital to attempting subsequently to prosecute the individual and seize and forfeit the proceeds.

Canada currently has several laws which enhance our ability to trace the proceeds of crime and to prosecute those who possess the assets. These laws, combined with the laws of conspiracy, give enforcement authorities significant powers to search for and seize evidence relating to the possession of any asset obtained either directly or indirectly from a serious crime, wherever it may have occurred.

The object of the crime is the secondary offence of possession. The laws of conspiracy in Canada make it an offence for anyone, whether in Canada or elsewhere, to conspire to possess the proceeds of crime in Canada. Thus, two or more people who are outside Canada at the time of the offence but who agree to possess assets which are directly or indirectly, in whole or in part, the proceeds of a serious (indictable) offence, commit an offence within Canada; the evidence which exists in Canada in relation to that offence may be seized.

Although this law seems wide in application, it has some limitations. Real property and intangible assets are not always seizable, although the person or persons may be convicted for possessing such property. When this class of property is also the proceeds of illicit drug sales, or other forms of consensual crimes, the problem of forfeiture becomes even more difficult, since there is no original legal owner to initiate legal action for the return of such property once it has been located. In addition, there are no freezing powers to prevent the disbursement of such funds. The entire process is even further complicated if the assets are located outside Canada. Thus, even following a successful prosecution, forfeiture of the property may prove impossible.

Canada is currently examining ways of improving the ability of law enforcement authorities to cause the freezing or seizure and subsequent forfeiture of all assets which are established to be the proceeds of criminal activity. The ability to recover the evidence of complex multi-jurisdictional laundering schemes is a further element of the study. The use of bilateral and multilateral law enforcement agreements and treaties may help to overcome major differences in legal systems and procedures. The expanded use and recognition of an investigational type of "letters rogatory," such as are currently in force in the European Economic Community, is also under consideration. This could involve a procedure to invoke search powers on the basis of investigative letters rogatory in the countries through which laundering schemes are operated. The use of the bankruptcy process to shift the legal title of property illegally acquired through crime of a consensual type, and to ensure the seizure, management, and liquidation of complex business enterprises created with the proceeds of crime, may also be resorted to in certain cases, both domestically and internationally.

DEPARTMENTS

New Books

by RON HALL

Cannabis: Health Risks

. . . by Oriana Josseau Kalant, Kevin O'Brien Fehr, Diana Arra, and Lise Anglin

This comprehensive annotated bibliography covers the literature from 1844 to 1982. For many decades, the annual volume of publications remained relatively steady, but with one exception. The big surge in the literature began in the mid-1960s and reached its peak in the mid-1970s. This volume consists of succinct abstracts of 1,719 papers by 1,891 authors and includes everything that dealt with, claimed, or clearly demonstrated adverse effects of cannabis on health, regardless of quality. Acute pharmacological and behavioral effects that have no demonstrable direct relation to health are not included. Since this bibliography deals with adverse effects on health, the potential therapeutic uses of cannabis are also excluded, except for occasional passing comments in papers that otherwise met the selection criterion. The abstracts are non-evaluative and it is up to the reader to make medical and scientific judgments on the merits of each publication. More than 540 key words have been used to provide subject access to citations.

(Addiction Research Foundation, Marketing Services, Dept JR, 33 Russell St, Toronto, ON M5S 2S1. 1983. 1,100 p. $40. ISBN 0-88868-081-3)

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. For further information, contact Margaret Sheppard at (416) 595-6150.

Drug Profiles

Number: 585.
Subject heading: Drugs - pharmacology.
Details: 28 min, 16mm, video, color.
Synopsis: A doctor gives a lecture on many drugs of abuse including both licit and illicit drugs. He discusses their pharmacology and effects on the human body systems. These drugs when used alone are quite dangerous, but when combined can cause even greater harm. Most of the drugs discussed have effects on driving skills. He concludes that one should not take lightly drugs and their use — they can be a lifetime commitment.
General Evaluation: Poor to fair (2.8). This film contained excellent information, however, the method of delivery (a lecture) was judged boring and unlikely to have impact on most audiences.
Recommended use: With a resource person this film could be useful with professional or community groups who require an overview of the use and effects of drugs of abuse.

Alcohol, Drugs and You: A Losing Combination

Number: 586.
Subject heading: Drugs and youth, alcohol and youth.
Details: 20 min, 16mm, color.
Synopsis: Athletes are training for track events; they see themselves as winners. A woman, sitting on a chair in front of a black background, says she wants to see some losers. The man with her shows people who have used all kinds of drugs for many different reasons. In between the vignettes of the drug users, the man and woman talk about what they are seeing and hearing, and she discusses how she is feeling about these losers.
General Evaluation: Poor to fair (2.6). While some of the vignettes were good, the group thought the film was disjointed and that the scenes with the man and woman detracted from the film's message.
Recommended use: With a resource person, this film, could be used with teenagers.

Staight Talk About Drugs: Psychedelics, PCP and Dangerous Combinations

Number: 587.
Subject heading: Drugs and youth, drug use: etiology and epidemiology.
Details: Four-10 min filmstrips/tapes, color.
Synopsis: The filmstrips deal with the drugs LSD, mescaline, psilocybin, THC (marijuana), and PCP. They show what happens when someone uses these mind-altering drugs — ranging from getting in touch with nature, to feelings of anxiety and paranoia. By themselves each one of these drugs can be dangerous, however, when used in combination with other drugs (eg alcohol), their use can be lethal.

General Evaluation: Good to very good (4.5). The photography in these filmstrips was exceptionally good. While at times they seemed to make taking psychedelics almost attractive, the message that they are unpredictable, and therefore dangerous, was clear.

Recommended use: With a resource person, could be used with 12 to 18 year olds.

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Other books

Problems of Drug Dependence, 1982 — Harris, Louis S. National Institute on Drug Abuse, Rockville, 1983. Proceedings of the 44th Annual Meeting of the Committee on Problems of Drug Dependence, held in Toronto, June 27-30, 1982; advances in treatment of drug dependence; chemistry and pharmacology; clinical pharmacology; drug abuse treatment; program reports. Index. 552p. US Government Printing Office, Washington, DC 20402.

Don't Panic! A Parent's Guide to Understanding and Preventing Alcohol and Drug Abuse — Peele, Stanton. CompCare Publications, Minneapolis, 1983. Extent of adolescent drug abuse; model for understanding drug abuse; prevention; parents' role. 37p. CompCare Publications, 2415 Annapolis Ln, Minneapolis, MN 55441. $2.25. ISBN 0-89638-068-8

The Purposes of Pleasure: A Reflection on Youth and Drugs — Hawley, Richard A. Independent School Press, Wellesley Hills, 1983. Drugs and the culture of youth; purposes of pleasure; drugs and learning; drugs and personal development; drugs and values; suggestions for policy and action. 173p. Independent School Press, Wellesley Hills, MA. ISBN 0-88334-171-9

Report on the Fourth World Congress for the Prevention of Alcoholism and Drug Dependency — Soper, Francis, A. (ed). International Commission for the Prevention of Alcoholism and Drug Dependency, Washington, 1983. Congress held in Nairobi, Kenya, Aug 31-Sept 2, 1982; social action toward prevention; legislative action for prevention techniques; rehabilitation and prevention programs in process; nutrition and social action; role of religion; scientific and medical research; findings and recommendations. 484 p. International Commission for the Prevention of Alcoholism and Drug Dependency, 6830 Laurel St, NW, Washington, DC 20012-2199.

Pot Safari: A Visit to the Top Marijuana Researchers in the United States — Mann, Peggy. Woodmere Press, New York, 1982. Marijuana usage; the plant, penalties, and analysis; marijuana and the brain; lung effects; marijuana and the heart; effects on sex and reproduction; marijuana and the immune system. 133p. Woodmere Press, PO Box 1590, Cathedral Station, New York, NY 10025. $8.45.

Professional's Handbook on Geriatric Alcoholism — Sherouse, Deborah L. Charles C. Thomas, Springfield, 1983. Aging; disease concept; assessment of alcoholism in the general population; medical and physician's issues; mental health; poly-drug misuse; elderly alcoholic as a unique treatment population; self-help groups; nutrition and exercise; organic brain syndromes; causes of excess mortality due to alcohol use/alcoholism. Bibliography, index. 226p. Charles C. Thomas, 2600 S 1st St, Springfield, IL 62717. $27.50. ISBN 0-298-04828-2.

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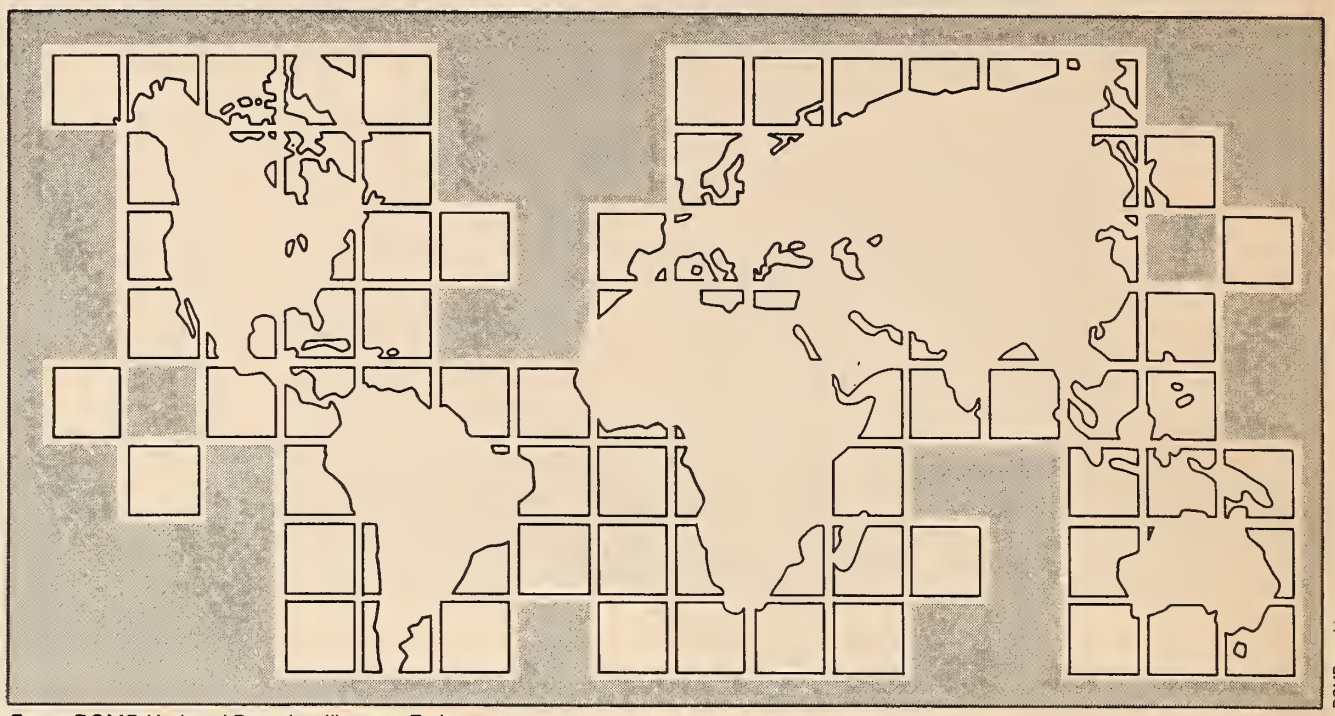
Drugs and the laundering game

By Superintendent Rodney T. Stamler, officer in charge, Drug Enforcement Branch, Royal Canadian Mounted Police, and Robert C. Fahlman, Chief, Research and Publications Section, Headquarters, Drug Enforcement Branch, RCMP.



RCMP graphic

From: RCMP National Drug Intelligence Estimate

Money and other valuable securities are moved out of Canada and into jurisdictions that have protected, secret, banking privileges for many reasons. Some are legitimate, or at least not contrary to the criminal law; others are not. These jurisdictions are commonly referred to as tax havens.

Use of tax havens has grown in popularity in recent times as one of the few ways of placing funds beyond the reach of tax collectors. Such guaranteed financial privacy became attractive to a variety of individuals, including some whose primary interest was not necessarily avoiding taxes. They became popular to fast-rising dictators and public officials who wanted a so-called "guaranteed pension plan" beyond the reach of their successors or the public. Finally, criminal organizations found tax havens too inviting to ignore.

The evolution of multinational banking systems and international business and commerce made it easy for them all to develop sophisticated laundering systems designed to move money obtained directly from criminal activity into foreign banks that were protected from intrusion by law enforcement officials.

For the criminal, including the one whose business is drugs, this financial privacy is indispensable.

Several European countries have long histories as world financial centres, with a minimum amount of financial regulations and strong secrecy laws. But today, many countries and territories are providing more than a tax haven.

Secret accounts

Some not only provide easy access to the banking institutions with secret numbered accounts, but also have extended corporate and secrecy laws to allow for the establishment of an unlimited number of beneficially-owned corporations that can be operated or manipulated by local agents or lawyers. When these corporate entities are combined with several numbered bank accounts, a maze of financial transactions can be structured in a way that the tracing of assets is a highly complex task. If questionable funds are then moved from one tax haven jurisdiction to another, the complexities are compounded.

To some degree, any country can be a tax haven and thus be used successfully to launder funds. Canada, for example, does not tax non-residents or foreigners to the same extent as it does its own citizens or permanent residents.

Pure tax havens exist, however, because countries have strong bank secrecy laws, they encourage or facilitate easy access to their banking facilities, they do not enter into mutual tax assistance treaties, and, finally, they are reluctant or hesitant to aid foreign countries requesting information about banking transactions for law enforcement purposes.

A number of different types of institutions are being utilized to move funds out of Canada to such tax haven jurisdictions. These include Canadian banks with international branches or facilities, trust companies and provincial banking institutions, shipping companies, real estate companies, travel agencies, money changers, insurance companies, finance companies, brokerage and investment companies, international trading companies, holding companies, and multinational corporations.

Although unlawful laundering schemes vary widely and can be as complex as legitimate business and commercial transactions, there are several commonly known methods of moving unlawfully acquired funds out of the country.

The majority of Canadian banks operate international departments and also have foreign subsidiaries in most tax haven countries. Through a variety of banking transactions, cash deposited in Canada can be transferred anywhere in the world. This can, of course, be accomplished through the use of a variety of corporations, business entities, or fictitious business transactions, all in the guise of legitimate commercial enterprises. The actual transfer may involve the issuance of a bank cheque or money order, or be carried out by electronic means, simply crediting an account abroad.

The advantages of this system are that it seldom attracts attention and is not easily identified as part of an unlawful scheme. The disadvantage is that if Canadian law enforcement authorities detect the unlawful acts and follow the transactions to the bank, records in Canada will provide evidence of all transactions. However, further protection can be obtained by the criminals if they are able to bribe bank officials who, in turn, may be in a position to make tracing of the funds through the bank almost impossible. In addition to long-established chartered banks operating in Canada, a number of foreign banks are performing a parallel service to the public in Canada. As well, hundreds of agents of foreign banks operate in Canada in a semi-clandestine manner. They are able to provide consulting services and arrange and/or facilitate the movement of money from Canada to banks in foreign jurisdictions.

Businesses and financial institutions involved in the exchange of money have also been known to accept large amounts of cash, thus facilitating a laundering system. Using a corporation as a front, a criminal will engage a foreign lawyer or business agent to represent his interests in a country where the criminal's corporation also has status. He will then make a large cash transfer to his corporation's foreign account through the money exchange.

Brokerage houses have also been used to transfer large amounts of cash. One scheme involves a foreign bank that unknowingly represents a criminal and places an order with a Canadian broker for a large sum in securities. The bank advises the broker that the funds will be paid for directly in Canada through a courier. The criminal then engages a courier who delivers the money in a variety of forms, including cash, and the securities are sent to the foreign bank — where they are later recovered by the criminal.

Certain travel agencies with multinational connections have also become involved in the movement of large amounts of money and are primarily involved in the laundering business. Although they charge fees to move currency from one country to another, the fees are not significant enough to deter the criminal. Because of the nature of their business, they can arrange to transfer large sums of cash directly to another country where they have an affiliate office. There, the money can usually be exchanged for foreign currency and moved onward simply using a banking system. The travel agency may or may not be aware of the true purpose of the transaction.

The safest way to move cash is simply to hand-carry the funds to a foreign country. The most popular method is for the criminal to engage a courier to transport the money out of the country in a suitcase, briefcase, or money belt, leaving no paper trail within Canada. A number of routes are available to such couriers, the most popular being by air to a European country or an offshore Caribbean island. Money couriers are often lawyers, accountants, or businessmen who may operate the laundering service for a fixed fee. Foreign bank agents will also act as money couriers.

Services provided

As well as the usual banking facilities, many banks in tax haven countries provide secret numbered fiduciary accounts, in which the names of depositors are held separate from the accounts themselves. The name may be held by a separate entity such as a trust company affiliated with the bank. In addition, one banking facility may be made up of numerous corporate entities. For example, the name of the depositor may be held by one corporation, the actual bank account by another, and the investment certificate issued by another. This type of system is designed to make it difficult for foreign courts or enforcement agencies to identify money flows within the institution.

Most offshore tax havens in the Caribbean and Europe have systems providing for the incorporation of business and holding entities that provide a high degree of anonymity to the beneficial owner.

This type of corporation, which may carry on business transactions within and outside the country, will be managed by a resident business agent, shown as the resident officer of the corporation. The local lawyers who incorporated the company will remain as the officers and directors on the documents of incorporation. The true or beneficial owner's name will only be recorded in a government department's books, which are kept secret by strict laws, making it difficult for foreign courts and officials to penetrate. The corporation may carry out banking transactions and own secret numbered accounts, both within the jurisdiction or in other tax free jurisdictions.

Barristers and solicitors in tax haven countries can be engaged by foreign criminals to incorporate business or holding entities. These entities are specifically allowed to operate tax-free and with maximum security under the law. The lawyers are permitted to remain as the directors and officers of the company and act for the beneficial owners. They are usually forbidden, through a form of solicitor/client privilege, to divulge the names of the beneficial owners of the corporations. In addition, the beneficial owners may be foreign tax haven corporations, which will provide double protection.

Generally, citizens of tax haven countries are not permitted directly to use the facilities of this class of corporation.

Repatriating funds

After money has been delivered safely to the tax haven country and is deposited in the bank in the name of a beneficially-owned corporation, only part of the laundering cycle has been completed.

The criminal, if he requires the use of legitimate funds in Canada, must now effect repatriation. Assuming the funds are in an offshore bank, he arranges the purchase of a Canadian investment by making a small down payment with "clean" money and then arranges to borrow the balance of the purchase price from the offshore bank or one of his offshore corporations. Continuing the charade, he then repays the loan as if it were a legitimate, arms-length transaction.

In this way, not only does he repatriate his money, but he also gets the opportunity to pay himself interest, which is deductible from this income for Canadian tax purposes. Once this loan is repaid, he can continue to lend himself more funds to acquire more legitimate assets.

This transaction rarely occurs directly with the foreign bank where the money is deposited; it usually involves several offshore corporations.

Instead of using a loan-back method, the criminal makes the investment using his foreign offshore company as the front. Legitimate businesses may accept the criminal as a "partner," who then makes his investment using the laundered funds via his foreign company. Doing this, the criminal purchases his own property, business, etc. at a highly inflated price, and then repatriates more funds to Canada.

Once the criminal becomes established in a quasi-legitimate business in Canada, he can facilitate the laundering of funds in a variety of ways. A common system is double-invoicing. An offshoot of this scheme involves invoicing non-existent property or merchandise.

Legislative controls

Until 1981, the financial flow resulting from street-level illicit drug sales was not subject to investigation in Canada. In that year, the Canadian government, support-

(See — Money-tracking — page 14)

THE BACK PAGE

Vol. 13 No. 2 2nd Class Mail Reg No. 2776 TORONTO February 1, 1984

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Business must face realities of drug culture

Security staff spot abuse clues

By Harvey McConnell

WASHINGTON — Company security officers can be vital links in helping employees with substance abuse problems — if they are backed by supervisory and union officials.

This has been the experience at General Motors (GM), says Russell Austin, director of GM's employee assistance program (EAP), the largest in the United States.

Mr Austin told a conference on substance abuse in the workplace, held by the American Society for Industrial Security here, that GM security staff are an excellent source of referrals to the EAP. "In many cases, security has the velvet hammer which can be used literally to force an individual to seek help.

"The plant security officers are the eyes and ears of what is going on in the work setting. For example, they can observe who is coming in late and leaving early; we in EAPs have an opportunity to piggyback on this."

Mr Austin said all too often, though, he has heard security people comment, 'Yes, I know he has been drinking, I can smell it, but if the supervisor allows it, why should I intervene?'

In other instances, if security officers act to force an employee to seek help, they are sometimes undermined by supervisors or union representatives who claim they'll handle the problem and tell security officers to stay out.

"If this happens, the employee learns to manipulate the supervisor and union to avoid the consequences of his action," Mr Austin said. Action must be taken if a security officer reports an employee; if this is ignored, employees believe they can beat the system.

Management must also watch for substance abuse among security staff. "No group is immune to the problems of drug use and abuse," Mr Austin added.

Drugs and industry: almost always reacting on a personal level

By Harvey McConnell

WASHINGTON — Any idea among United States company executives that they can hire people who have never used drugs is a dream of the past.

"Corporations cannot afford not to be involved in the problems of drug abuse," said Donald Fletcher, director of government affairs for Smith, Kline and French Laboratories, at a conference on substance abuse in the workplace, held by the American Society for Industrial Security here and the Haight-Ashbury Free Medical Clinic.

The annual loss of production through alcohol and drug abuse in the US is approximately $16.6 billion a year. "And that's just straight up competitive loss," he said. Nor does this include "medical expenses and crime and a whole multitude of other costs that could be associated with it."

While an absolute case can be made by talking only about "the bottom line," corporations care about employees and have to deal constantly with their problems. Seen in this light, "there is a world of convincing evidence about why corporations should be involved in substance abuse problems," Mr Fletcher said.

"A lot of junkies figured out a long time ago there was no way, under any circumstances, that a corporation was going to be able to hire and keep employees who didn't use alcohol." On the other hand, a decade or so ago, many companies searched for ways to screen out drug abusers among potential employees, and to get rid of abusers already in the work force.

Some companies tried lie detector tests and found most prospective employees would be rejected if they were asked if they had ever used drugs. The companies discovered the question to ask is whether the prospective employee is a current drug user.

"Companies used to think they would not hire anybody who had used drugs: that is a dream of the past. There is no chance to keep out anybody who has used drugs," he continued.

Mr Fletcher said there is often a free information exchange among corporations about company policy on certain issues. When he is consulted, "I have told them they must sit down and decide to handle the substance abuse problem like they handle other problems in the corporation.

"The best prevention tool you can have is for every member of a corporation to know clearly what that policy is, and it has to be written out. Unless you can prove every employee knows what the policy is, you probably can't do anything about it."

A good policy, plus backing from people at the top, creates an effective prevention program.

Mr Fletcher said all it takes to convince most people of the wisdom of an effective policy is for them to witness the recovery of an employee.

"Despite all the statistics and all the sophistication that we have in our corporations and our life today, we still are almost always reacting to things on a personal level," he added.

AIDS, drug use link under study

WASHINGTON — The New York State Division of Substance Abuse has been granted $218,000 by the United States department of Health and Human Services (DHHS) to try to find out why intravenous drug users contract acquired immune deficiency syndrome (AIDS).

The study will be carried out by New York officials in the New York City metropolitan area.

The DHHS pointed out that more than 90% of AIDS victims who are heterosexual drug users live in the New York area (**The Journal**, Dec 1983).

INSIDE

Drugs — more potent, available, abused

World drug abuse at unprecedented level

By Behrouz Shahendah

VIENNA — The International Narcotics Control Board (INCB) has issued a strong warning that drug abuse has reached "unprecedented dimensions" in many member countries — and it points to the tendency of some governments to underplay the importance of cannabis use as a significant factor in this increase.

More countries are being afflicted as "drugs of greater potency are more widely available and consumed in more hazardous ways," says the 1983 report of the 13-member United Nations drug control body.

Contributing to the escalation, it says, is the assumption in certain countries that "unrestricted use of some drugs regarded by them as less harmful would permit better control of other drugs which they deem more perilous to health."

However, the INCB says signatories of international drug control treaties are not free to select which controlled substances to restrict to medical and scientific uses.

Cannabis was specifically mentioned in this context and the INCB urges governments to be aware of the international implications in decisions concerning control of this drug.

"Non-medical consumption of cannabis is illegal under the 1961 Convention (Single Convention on Narcotic Drugs)," states the report. "And . . . no party to the Convention can authorize such use without being in violation of the Convention."

The sale of drug paraphernalia and publications promoting illicit drug use also comes under heavy fire. The INCB points out "this approach opens up dangerous perspectives making drug abuse appealing to large segments of the general public."

Availability of narcotic raw materials has increased, and large

(See — Stockpiling — page 2)

NEWS

Briefly . . .

Thai opium crop

BANGKOK — Drug enforcement officials in Thailand estimate the opium crop in the Golden Triangle this year at 300 tons, about the same as last year. To underscore their efforts to control the drug trade, however, police here recently burned more than 18,000 lbs of confiscated narcotics in a public display. The pyre was said to contain 824 lbs of heroin, 457 lbs of morphine, and 9,240 lbs of marijuana.

Roadside warnings

GRAND RAPIDS, Minn — Burma Shave highway signs have been revived here to warn motorists of the dangers of drinking and driving. Six signs, each containing part of a jingle, stretch along the roadway to entertain and caution drivers at the same time. *Alcoholism Update* reports that a new jingle, winner of a high school competition, warns: Driving at night . . . full of liquor . . . may make death . . . come much quicker.

High taxes hurt

TORONTO — Canadian distillers are complaining high taxes have meant drops in liquor sales and may result in layoffs in the industry. They're getting the message to consumers through an advertising campaign outlining who gets what from each bottle of liquor sold. In Ontario, from a 750 ml bottle of Canadian whisky selling for $13.50, the distiller gets $2.38, the federal government collects $3.35 (up 42% from 1980), and the Ontario government gets $7.77 (up 52%). The distillers report that, across Canada, liquor sales dropped 7% in 1983 and 5% in 1982.

'Let me drive you'

CALGARY — More than 2,000 bumper stickers have been distributed to taxicabs throughout Alberta and in Yellowknife, Northwest Territories, as part of an Alberta Medical Association campaign against drinking drivers. "Drinking? Let me drive you" is the message. The campaign was launched in conjunction with the volunteer organization People Against Impaired Drivers (PAID).

Paraquat antidote?

EDINBURGH — Companies producing paraquat, a toxic herbicide used widely for marijuana plant destruction, should "plough some of their profits" into developing an antidote to the compound, says poisons specialist Laurence Prescott, consulting physician to the Edinburgh Regional Poisons Treatment Centre, in a report in *Doctor*.

MDs debate drink age

CALGARY — Alberta doctors decided by a narrow margin at the annual meeting here of the Alberta Medical Association not to ask the government to raise the minimum drinking age from 18 to 21 years. The decision was in direct contradiction to doctors in neighboring British Columbia who supported a similar recommendation to raise the drinking age at their annual meeting (**The Journal**, Sept 1983).

Tough DWI stand may impair treatment

ATLANTA — Concerted United States federal and state efforts to force drunk drivers into treatment may deliver them to incompetent clinics.

This is a major worry of LeClair Bissell, MD — former president of the American Society on Alcoholism and a consultant — particularly since many officials and legislators in Washington have now adopted a "law and order" approach to treating problems.

Dr Bissell told the Southeastern Conference on Alcohol and Drug Abuse here that she recently testified in a case involving a woman still actively drinking when she finished treatment. The clinic told the state the woman had successfully completed the program.

Later, the woman was in an accident which crippled two teenagers.

Said Dr Bissell: "The state implied to her they had chosen good treatment for her own good, and if she followed their recommendations, all would be well. She did, in good faith, follow the recommendations, and tragedy resulted."

Bissell: clinics less competent

Dr Bissell said: "I think we are going to see more and more of this." As more drunk drivers are forced into treatment, "clinics that are less and less competent are being delivered the patients."

As for treating alcoholics, Dr Bissell said the field is doing itself a great disservice by taking only the disease approach to the problem and trying to debunk various other theories, from stress to behavior modification. There is some truth in all of them although they won't work as a single treatment for such a complex problem, she said.

The primary illness approach is by far the best, she said, but having gotten patients sober and drug-free, "we can then turn around and reach back for all of these other approaches and ways of thinking."

This means "acknowledging that how and when alcohol is sold does make a difference; raising the drinking age to 21 will save a lot of lives; changing laws and behavior in treating drunken drivers will certainly alter things.

"Very frequently alcoholics are drinking because of emotional pain or because their social setting causes stress and problems, in such a way that, if we send them back to these settings without any changes at all, the chances of their staying sober are almost zilch. And there are a lot of behavior model techniques which can be extremely useful."

Our future task is "not throwing out the good stuff that was in some of the theories that have been largely debunked, but sorting through it again for that which is of value. This may help us reach those patients — the other 40% who don't do brilliantly when they are discharged — with something else, in addition to what we are offering now."

Dr Bissell said another concern is the rapid growth of large chains of treatment facilities for drug-dependent people. The legitimate desire to make a profit could persuade many groups to do away with expensive items such as family therapy and after-care and follow-up services.

At the same time, the free-standing institution may be forced to change or face financial competition it cannot meet.

Dr Bissell called on those concerned to band together and become politically active. Politicians at every level do respond to lobbying and promises of support, she said.

If the field does not become more politically active, more and more punitive actions will be taken against drunks, she said. It will be considered more of a sin and crime than it is already becoming, "and the law and order reaction will get worse and worse."

FDA to restrict look-alike pills

WASHINGTON — The United States Food and Drug Administration is to ban the sale of look-alike stimulant drugs.

At the same time, the agency has decided that drugs containing any two of the ingredients caffeine, phenylpropanolamine, and ephedrine will be banned until manufacturers get approval to sell new, safer products.

The three ingredients are found in most over-the-counter diet pills taken by an estimated four million people in the US who want to slim, and an unknown number of young people looking for a high.

Heart ills top cancers as cigarette-smoking risks

WASHINGTON — Most people in the United States are not aware cigarette smoking causes more deaths annually from coronary artery disease than from all cancers.

US Surgeon-General C. Everett Koop says smoking is an incredible assault on health, accounting for nearly 10% of all deaths in the US.

The exact mechanisms between cigarette smoking and heart disease have not yet been elucidated, he said in a report on the health consequences of smoking, but risks from cigarettes are greater than from high blood pressure or high cholesterol levels. That there is a link is beyond question, points out Dr Koop.

He says smokers are 70% more liable to have coronary heart disease than non-smokers, but could cut the danger of heart attacks by 45% if they stop, especially if they are less than 65 years.

He called for more public and private efforts to educate the public and said stronger warnings should be put on cigarette packs.

Stockpiling of opiates poses threat for 1984

(from page 1)

volumes of heroin and cocaine are being manufactured close to poppy and coca leaf cultivation areas, says the document.

As a result, local populations are suffering the consequences of the illicit use of these drugs. Drug use and drug trafficking also affect the economic development of many countries and contribute to "crime, violence, and corruption."

Psychotropic substances like amphetamines or barbiturates are being abused increasingly to an extent "probably greater than commonly assumed," the report continues. And contrary to early expectations, control of pyschotropics has proved difficult.

"The number of clandestine laboratories producing certain of the psychotropics is growing in many areas of the world, and diversion of such substances from licit channels continues to rise," the report says.

New drugs are being regularly introduced and it is important to include substances warranting control in international treaties.

The INCB also asks countries placing new drugs under national control to give equal attention to the reasons for control when exporting the drugs, "even though the substance has not yet been placed under international control."

The report notes that with respect to the demand and supply of opiates for medical and scientific needs, a balance was achieved in 1982 and 1983.

However, over-production appears likely for 1984, and "the possibility of an increase in the already excessive stocks cannot be excluded."

In general, "two factors continue to cast a shadow over the market in opiates: the existence of stocks of opium in India and poppy straw in Turkey which are capable of meeting demand for several years, as well as an excess capacity for the processing of raw materials."

The situation in most regions of the world deteriorated over the year, the report says. The Near and Middle East remain major sources of illicit opiates, and seizure data show that more than one-half of the heroin consumed in North America and more than three-fourths of that consumed in Western Europe come from these areas.

South Asia and East and Southeast Asia are also major illicit production regions with considerable trafficking and abuse, the report notes.

Western Europe and North America have developed into major markets for illicit drugs being supplied from inside and outside the regions. Bolivia and Peru remain major sources of coca leaf and cocaine, with Colombia providing the main outlet for these drugs.

"Traffickers are endeavoring to establish Africa as a major source of cannabis trafficked to Western Europe, as well as a major illicit market for psychotropic substances," the report states.

Large quantities of an amphetamine preparation compounded with aspirin continue to be diverted from licit trade and are available for abuse in many African countries.

A similar trend with methaqualone and secobarbital has also been detected, and the INCB reminds all manufacturing and exporting countries that "there exists little or no medical requirement for substances included in Schedule II of the 1971 Convention on Psychotropic Substances, in Africa.

"There can, therefore, be no justification for large exports of these substances to Africa. The Board is carefully reviewing these questions with the governments concerned."

In conclusion, the report notes "renewed dedication, vigilance, and action" is required by governments to contain and reduce supply while developing adequate demand reduction programs." Any "slackening in vigilance . . . may create a climate of permissiveness to increased abuse."

UK may seize all assets of drug traffickers

LONDON — Suspected drug-traffickers here could soon have cash and property seized unless they can prove these assets did not come from the proceeds of illicit drug deals.

This is one of the recommendations being examined by a committee set up four years ago to report on *The Profits of Crime and Their Recovery*. The committee includes legal experts, representatives from Scotland Yard, and an accountant, and is expected to report in the near future to British Home Secretary Leon Brittan.

The committee was formed not long after the House of Lords ruled that profits from a drug ring broken up during the now-famous Operation Julie (**The Journal**, July 1980) could not be confiscated.

Publicity may invite abuse

New solvent danger cited

By Tim Padmore

Correspondent Eleanor LeBourdais writes: Liquid Paper, a dab-on correcting fluid, is freely available from office supply stores. It contains a solvent, trichloroethane (TCE), used as an anesthetic agent until it was replaced by more effective drugs.

TCE may cause brief euphoria but can lead to death as a result of respiratory failure.

The effects are often irreversible as TCE sensitizes the heart's muscle lining to adrenalin, meaning agents administered to restore heartbeat fail to work. The substance is used in many household cleaning agents and paint thinners.

VANCOUVER — A second Canadian child has died, apparently after inhaling fumes from Liquid Paper — a commonly used correcting fluid.

Kissaa Anne Annis, 14, of Prince George, British Columbia, died Dec 12, after sniffing the substance, which contains the solvent 1,1,1-trichloroethane (TCE).

In September, a 12-year-old Saskatchewan girl also died minutes after inhaling fumes from Liquid Paper, says Saskatchewan coroner Dr Joseph Chorney.

Gillian Willis, spokeswoman for the BC Drug and Poison Information Centre, told **The Journal** the Prince George death was probably precipitated by newspaper reports of the earlier incident.

"This always happens," she said. She cited clusters of poisonings from the freon propellant in no-stick cooking spray as another example of the power of publicity to tempt potential abusers.

The potential hazards of the solvent are not new.

Ms Willis said she did a literature search in 1981 and turned up reports of 30 deaths from the solvent, also used in products like paint thinners.

One reference cites 13 deaths; 10 were judged accidental, one, a suicide, and two, the result of solvent abuse. (The reference, which includes citations of other papers, is *Clinical Toxicology*, Vol 9, pp 69-74 [1976].)

One other TCE abuse death has been reported in Canada — a 16-year-old inmate of the Ottawa-Carleton Regional Detention Centre died in 1980.

Ron Mackay is product reliability manager for Toronto-based Paper Mate Canada, a division of Gillette Canada Inc, the manufacturer. He said the wording of a warning for Liquid Paper is currently being worked out and that he met last month with company legal and medical experts in Boston, headquarters for Gillette Co.

In Ottawa, Alan Cotterill, project officer for the chemical hazards division of the ministry of consumer and corporate affairs, told **The Journal** the problem has been discussed with the manufacturer.

He said the government has not tried to regulate sales of abuse-prone solvents, but is working with industry through a joint task force, which includes a representative of the Addiction Research Foundation of Ontario, Dr Adrian Wilkinson (**The Journal**, Oct 1983). One result is the Retail Merchants Information Program on Solvent Abuse, in operation since August, through which merchants are being asked to display merchandise with abuse potential in ways that will discourage shoplifting, and to limit quantities sold. The success of the program is to be reviewed this spring.

Mr Mackay said Liquid Paper is only dangerous when abused.

Ms Willis agreed. "It's one of the safest to use in terms of liver or kidney toxicity, but inhalation of high concentration sensitizes the myocardium to stimulation by circulating adrenalin."

The overstimulated heart muscle may then go into fatal spasms.

Lack of oxygen associated with sniffing fumes from a closed container may also contribute, she said.

Kissaa's mother, Sharon Annis, said after her daughter's funeral:

"I asked (her friends) what kind of high they got out of sniffing it, and they said they went dizzy for about half an hour, then got a headache.

"The problem is that if parents suspect their children are doing drugs and check their pockets and find Liquid Paper, it seems okay because it's widely used in school and just about everyone has some at home. It's not like finding marijuana or pills in their pockets. It's a hard lesson."

Paper Mate also produces a water-based correction fluid called Mistake-Out, which, Ms Willis said, has no abuse potential.

Liquid Paper: just about everyone has some at home

Glue sniffing rise prompts new guidelines in the UK

By Alan Massam

LONDON — The British government has introduced a set of voluntary guidelines, agreed to by retailers, aimed at reducing the problem of glue sniffing.

The objective is to alert retailers of volatile products so that sales assistants will be able to recognize potential sniffers and know how to refuse to sell products they fear might be abused.

The Department of Health and Social Security is sending a poster to appropriate retailers, stating that the management reserves the right not to sell certain products.

A department spokesman said: "The guidelines have been drawn up by trade representatives who share the view of many professional people, that it would be unwise to identify potentially misusable products since this might encourage experimentation.

"We are also giving additional guidance to professionals in the field and giving urgent consideration to the case for banning the sale of glue-sniffing kits."

Concern over the sale of glue-sniffing kits follows the conviction of two shopkeepers who were brothers.

Both men admitted selling glue to children from their newsagents' business in Saltmarket, Glasgow. They were both jailed for three years.

The case made Scottish legal history after an earlier ruling at the Court of Criminal Appeal in Edinburgh that such sales were a crime in Scotland. Prosecutor Donald McKay said the matter first came to police attention in 1981 when the problem of glue sniffing in Glasgow was causing serious concern.

One of the brothers had refused to stop selling the glue with plastic bags from which it could be sniffed because he said he understood it was not illegal.

A Home Office spokesman said later that there was no equivalent offence in England and Wales. Any change in the situation would require legislation.

Bosses should manage, not treat

By Harvey McConnell

WASHINGTON — Many supervisors are forced to flounder when dealing with employees with addiction problems.

But workers with alcohol or drug difficulties should be treated no differently than those with high blood pressure or faulty alarm clocks, believes John Williamson, manager of Industrial Relations for the Carpenter Corporation, Bridgeport, Conn.

Mr Williamson said supervisors are skilled at determining how employees meet job performance requirements. They should be concerned not with whether workers are alcohol or drug involved, but rather with their ability to perform their jobs satisfactorily.

Mr Williamson told a conference on alcohol and drugs in the workplace held by the Bureau of National Affairs, a private advisory organization, that whatever the problem — drugs, alcohol, money, children, or spouses — it is not the responsibility of supervisors to diagnose problems or prescribe and administer treatment.

A chronically late employee is told he should leave for work earlier, or replace his car. "But we don't set the alarm for him, and we don't take out the loan and buy the new car for him. These are his responsibilities," said Mr Williamson.

If an employee gets dizzy the company nurse may note high blood pressure and refer him to his personal doctor. But the supervisor, or nurse, does not diagnose hypertension, or prescribe medication. The responsibility to get expert advice rests with the employee, he said.

Why then, when addictions are involved, "do we so quickly want to change these well-established principles?" Mr Williamson asked. Why does a supervisor have to catch an employee "with the goods" or "in the act?" This way the supervisor is playing from weakness, "and the odds are he'll lose.

"His best opportunity for success is to play from his strength — his knowledge of how the employee meets job performance requirements. He is then able to build a strong case not based on whether the employee is alcohol or drug involved, but rather on the employee's ability to perform satisfactorily."

This means progressive discipline, Mr Williamson added.

Redundancy register chief speaks out

By Wayne Howell

Recently the United States withdrew its support from the United Nations Educational Scientific and Cultural Organization (UNESCO). The withdrawal from the UNESCO was allegedly based on US disapproval of the UNESCO's meddling in Third World politics. But according to Phillipe de Montaguard-Vaillancourt, chairman of the UNESCO's *Regie de Redondance*, there is more to it than that.

M Montaguard-Vaillancourt feels that US President Ronald Reagan's administration was responding to the intense lobbying of the addictions establishments in the US and in other countries of the so-called free world, which convinced him that the Regie de Redondance (redundancy administration) was a grave threat to their continuing existence.

Spokesmen for the Reagan administration say this is nonsense and just the kind of thing one would expect from Montaguard-Vaillancourt who, they say, could teach the UNESCO Director-General Amadou Mahtar M'Bow a thing or two about financial impropriety and administrative excess. (The Director-General's transgressions have been well reported in the press. Montaguard-Vaillancourt's alleged impropriety was to have moved the headquarters of the Regie from Paris to Moulin-a-Vent at considerable expense, just to assure himself that his *Beaujolais nouveau* really was *nouveau*.)

One has to admit that there is no apparent reason for the Regie to have its international headquarters in a small town in the middle of the Beaujolais countryside. But, on the other hand, there is no apparent reason why the International Court of Justice should be in The Hague — are we to accuse the learned justices of locating there because of a secret passion for Gouda cheese? I am willing to give M Montaguard-Vaillancourt the benefit of the doubt and to hear his story:

According to M Montaguard-Vaillancourt, the trouble started when the Regie began to exercise its mandate and start to declare certain concepts and ideas redundant once statistics showed they had been expostulated and/or explained or/and expounded more than 10,000 times at public forums around the world. Once a subject was placed on the Redundancy Register, the UNESCO would no longer support its propagation and would actively encourage people to boycott any public forum where the subject reared its redundant head.

One can well imagine the consternation the Redundancy Register aroused in the addictions community. Consider:

- In 1983, there were, in the US alone, 566 conferences in which the subject of the different needs of recovering male and female alcoholics was on the agenda.
- In the same year, and despite its modest population, Canada managed to host 18 conferences in which the subject of why it is better to have an employee assistance program than not to have one was on the agenda.
- In Great Britain in 1983, there were 340 symposia in which the multifactorial causes of alcoholism were to be multifactored.

But the full impact of the Redundancy Register becomes clear when one considers that in 1983, in the three aforementioned countries plus France, Germany, and all of Scandanavia, there were 23 conferences, many of them major undertakings at major hotels with rooms costing upwards of $100 a night, which were left with no subjects at all to discuss, since every single subject on their proposed agendas was on the Redundancy Register. Of course, they went ahead and dealt with these subjects anyway, complete with the usual workshops, and participants were none the wiser. But the organizers could see the handwriting on the wall, and that is when the Addictions Industrial Complex began its intensive lobbying campaign which culminated in President Reagan's decision to pull out of the UNESCO.

In any event, that is the belief of M Montaguard-Vaillancourt of the Regie de Redondance of Moulin-a-Vent, Beaujolais, France.

I would caution you to view his story with some suspicion — the word of an international bureaucrat who allegedly squanders UN funds so he can be close to his favorite vineyard is not necessarily to be trusted. Take, for instance, this business of the Redundancy Register and the figure of 10,000. That sounded a little bizarre to me and so I checked it out by looking through old copies of **The Journal**. **The Journal** provides comprehensive coverage of most major addictions conferences in North America and a survey of past issues show that it has only reported conference speeches on the multifactorial causes of alcoholism 50 or 60 times.

NEWS

RESEARCH UPDATE

Moderate alcohol use lowers bile cholesterol

Evidence that moderate alcohol consumption has a protective effect against cholesterol gallstones and cardiovascular disease has been strengthened by a study at the University department of medicine, Bristol Royal Infirmary, Bristol, England. Researchers John Thornton, Carol Symes, and Kenneth Heaton tested the effects of moderate alcohol consumption on bile cholesterol and plasma high-density lipoprotein (HDL) cholesterol concentrations. Twelve healthy volunteers who consumed little alcohol usually were asked to drink a half bottle of white wine daily for six weeks and then abstain from alcohol for six weeks. The study found that during the period alcohol was consumed HDL cholesterol (an important anti-atherogenic) rose significantly, and bile cholesterol saturation (a fundamental prerequisite for cholesterol gallstones) fell significantly. The effect was reversed during the abstention period. The researchers concluded "our findings indicate that abstention from moderate alcohol consumption should not be one of the many possible deprivations recommended to patients with these diseases."

The Lancet, Oct 8, 1983, n.8354:819-822

Family support for opiate addicts

Maximum family involvement in treating opiate addicts is associated with a better prognosis, says a Connecticut study. To test the value of family support in treating opiate addicts, researchers from the department of psychiatry, Connecticut Mental Health Center, and the drug dependence unit, Yale University School of Medicine, New Haven, compared four groups of addicts in a naltrexone program — 28 addicts with their spouses; 27 living with their parents; 28 who lived alone; and 23 who denied their drug abuse to family members with whom they lived. The first two groups participated in family therapy and remained drug-free significantly longer than the other two groups. In addition, addicts who denied their drug use to their families remained drug-free for significantly less time than those who admitted their abuse. Those who admitted their drug abuse to their spouses but not their parents remained drug-free for shorter times than married addicts who also told their parents. The researchers concluded that despite the limited generalizability of the study, it suggests "a definition of family denial as a prognostic factor in drug addiction."

Journal of Nervous and Mental Disease, October 1983, v.171:611-616

FAS and nail dysplasia

Abnormal fingernail or toenail growth is seen in more than 20% of reported cases of children with fetal alcohol syndrome (FAS). So say California researchers who have published case studies on this aspect of the syndrome caused by maternal drinking during pregnancy. Lucy Crain, MD, Nancy Fitzmaurice, and Carol Mondry, MD, reported findings of substantial dysplasia of fingernails and toenails, including the complete absence of some nails, in four siblings with FAS. They said dysplastic nails may be an under-emphasized feature of FAS "and we recommend clinicians carefully examine the nails of all digits, especially when FAS is suspected." The three researchers said there is a need for primary physicians to describe specifically any abnormal nail conditions to help eventually determine "whether specific teratogens affect certain digits in predictable patterns of malformation."

American Journal of the Disturbed Child, November 1983, v.137:1069-1072

Patient-treatment matching

A prospective study of six substance abuse treatment programs indicates that matching patients to the most appropriate programs has a definite beneficial effect. The evaluation involved 189 alcohol-dependent and 321 drug-dependent patients who applied for treatment during the first nine months of 1980. Researchers at the drug dependence treatment unit, Philadelphia Veterans Administration Medical Center, and the departments of psychiatry, University of Pennsylvania, and Thomas Jefferson University, Philadelphia, divided the patients into one of four inpatient and two outpatient programs based on a psychiatric severity rating obtained at admission, which delineates alcohol or drug dependency and severity of psychiatric problems. When treatment beds or places in the appropriate program were not available, those patients were described as being mis-matched. Over the initial treatment period and a six-month follow-up after admission, the study found those patients matched to the appropriate program were rated as significantly more motivated for treatment and had a 17% better outcome than the mis-matched patients. The researchers concluded the findings have significant cost saving implications and that matching was well accepted by patients and staff.

Journal of Nervous and Mental Disease, October 1983, v.171:597-605

Alcohol and attention deficit disorder

A higher incidence of alcohol abuse has been seen in the fathers of adults with attention deficit disorder than in a control group of psychiatric patients with other disorders. The study by researchers from the department of psychiatry and behavioral sciences, University of Louisville, Kentucky, looked at 22 hospitalized psychiatric patients with the disorder, which is characterized by hyperactivity with perceptual dysfunction. They found a greater prevalence of alcohol abuse in the fathers of the attention deficit disorder patients (77%) vs the fathers of control patients (25%) and also a higher rate of alcohol abuse in the siblings of the study group and the patients themselves, although the latter two differences were not significant. The researchers said the etiology of the relationship was not known and more study is necessary.

Journal of Clinical Psychiatry, October 1983, v.44:379-380

Pat Rich

Nationwide drinking age hike proposed by US commission

By Harvey McConnell

WASHINGTON — A federal law to force states in the United States to raise the minimum drinking age to 21 or lose federal highway construction grants has been proposed by the US National Commission Against Drunk Driving (formerly the Presidential Commission on Drunk Driving).

Studies show that raising the minimum age reduces fatal nighttime car crashes involving 18 to 21 year olds, says the commission, which was set up in 1982 and is headed by former transportation secretary John Volpe.

US President Ronald Reagan said in an accompanying message that drunk driving "is a national menace, a national tragedy, and a national disgrace," and he hopes the report will speed moves to remove the hazard.

But, a White House spokesman said the administration did not believe the government should impose the minimum 21-year drinking age.

The proposal to withhold financial help for highway building — some $12 billion was provided to states in the last fiscal year — was used by the government to impose the national US speed limit of 55 miles per hour. At present, 19 states have a minimum drinking age of 21, and the District of Columbia is considering similar legislation.

The committee noted lack of uniformity on the legal drinking age is serious because young people commute to nearby states where the drinking age is lower.

It called for greater law enforcement efforts against drunk drivers, mandatory legal sanctions for first offenders, and an end to plea bargaining (reducing the charge, and/or penalty, in return for a plea of guilty).

Another far-reaching measure would be an implied consent law: all drivers with licences would automatically consent to blood or urine sample tests to determine if they have used alcohol or drugs.

Teenagers would get provisional driving licences only, which would be withdrawn for convictions of drunk driving or refusals to take blood or urine tests.

Other recommendations are for legislation to eliminate drunk drivers' escaping civil actions by filing for bankruptcy, and improved reporting systems so the names of drunk drivers quickly find their way onto computers of state law enforcement and licensing agencies.

Government anti-smoking action urged

UK docs target 'hidden holocaust'

By Alan Massam

LONDON — The Royal College of Physicians has issued its fourth and bluntest report* on the medical consequences of smoking, claiming the British government should tackle "this hidden holocaust with the urgency once given to cholera, diphtheria, polio, and tuberculosis."

It estimates that 100,000 people are dying prematurely each year in Britain from the effects of the habit, yet no effective action has been taken to abolish tobacco advertising.

The report, by a working party of physicians under College president Sir Douglas Black, calls for:

- a ban on the sales promotion of tobacco products;
- an annual increase in tobacco tax, so that the cost of smoking rises faster than inflation;
- continued efforts to reduce the tar, nicotine, and carbon monoxide yields of cigarettes;
- further research into what components of tobacco smoke are responsible for cardiovascular disease, and what factors might influence susceptibility to the smoke; and,
- tougher regulations to prevent the sale of cigarettes to children.

At a press conference to introduce the report, a member of the working party, Dr Charles Fletcher, said: "Politicians are not in the least bit interested in health, except their own."

Later the same day, junior health minister John Patten received a delegation from the Freedom Organization to Enjoy Smoking Tobacco, a tobacco-industry-sponsored lobby, and said: "I believe that, within the restraints of a free society, the policies the government has adopted are proving generally effective."

**Health or Smoking?* Royal College of Physicians, St Andrew's Place, Regents Park, London NW1.

Family doctors will study how to counsel smokers

LONDON — The Royal College of General Practitioners (RCGP) in association with Lundbeck Ltd (manufacturers of nicotine-laced chewing gum) estimates that Britain's National Health Service spends £155 million annually treating smoking-related diseases.

In a statement issued shortly after publication of the latest Royal College of Physicians report (see above), it announced the establishment of a series of workshops around the country to help family physicians develop skills in counselling smokers.

"The idea behind the series is simple," a spokesman told **The Journal**. "If a doctor understands why a patient smokes, he is in a good position to recommend ways the patient can stop."

He said the RCGP estimated that 70% of Britain's 15 million smokers want to give up the habit. The advice of a family physician was the most important factor in motivating people to stop smoking.

Later, junior health minister John Patten told **The Journal**: "The government will continue to pursue its existing policies. There has been a 20% decline in United Kingdom cigarette sales over the past four years, a significant fall in the proportions of both men and women who smoke cigarettes, and continuing reductions in the tar yields of cigarettes for those who continue to smoke.

"Special efforts will be made to ensure that children and young people are fully aware of the health risks associated with cigarette smoking before they consider taking up this dangerous habit. I am extremely concerned about the level of smoking among secondary school children revealed by the recent Office of Population Censuses and Surveys report. When I see representatives of retailers (of cigarettes) I will be pressing them to suggest how their members can tighten up on the evidently widespread abuse of the law on sales of cigarettes to children."

Beware of disillusionment Niven cautions parents

WASHINGTON — Major inroads can be made against substance abuse by society, but problems will never be eradicated, warns Robert Niven, director of the United States National Institute on Alcohol Abuse and Alcoholism.

Niven: the greatest mistake

Dr Niven told the conference here of the National Federation of Parents for Drug-Free Youth (NFP) that while such organizations as theirs can spring up and have a major impact on dealing with a problem in society, a long-term view must be taken.

In this way, the NFP could "avoid the possibility of having a good proportion of your membership get disillusioned if they devote a tremendous amount of effort for two or three years and then don't see the amount of progress that we would all like to see."

Substance abuse problems are not going to be solved by the current administration or the next, or the one after that, Dr Niven added, "although I would be delighted to be proven wrong, and it would be the greatest mistake I have ever made. But I don't think I will be, particularly when we talk about alcohol."

Current anti-drug education 'a colossal failure'

By Lynn Payer

NEW YORK — Legal restrictions on drug use have made the problem worse and should be gradually dismantled, Andrew Weil, MD, told the Health and Addictions conference here.

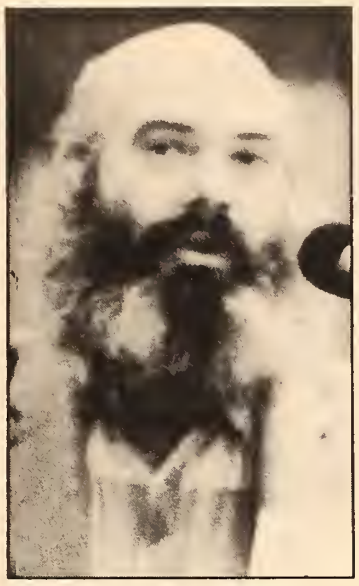
More effective, he said, would be restrictions on advertising, and "real" education of both the public and the medical profession about the dangers of drugs.

"We have attempted to deal with our drug problems for the past 100 years by defining what we don't like as bad and trying to make it go away. That approach has been a colossal failure. More and more people are using more and more drugs in worse and worse ways."

Dr Weil differentiated between lifting legal restrictions and making drugs freely available, explaining that he advocates decriminalization.

"I would maintain that the single greatest factor that leads young people to want to try illegal drugs in the first place is their illegality and their prohibited, forbidden nature," he said.

"I'm quite sure that in a society where there was no big deal made about marijuana, where it was just another roadside weed, the percentage of people using it would be very small."



Weil: drugs as good and evil

But Dr Weil did not think drugs could suddenly be made legal, although "I would like us to stop this course we have been on for 100 years, which is just leading us on to worse and worse situations."

While "real" drug education for both doctors and laymen could lessen the effects of drug abuse, he said current attempts at education, as well as legislation, failed to show the true dangers.

"There is a very strong human need to classify drugs as good and evil . . . there is also a very strong human ability to rationalize those decisions."

However, alcohol is by far the most dangerous substance in pharmacologic terms.

"There is no other drug that comes anywhere near alcohol in terms of acute medical toxicity or chronic medical toxicity," Dr Weil declared. "There's no drug that approaches alcohol in terms of behavioral toxicity. The only drug for which there is an unarguable association with crime is alcohol. Yet its use is not only tolerated, but promoted."

Tobacco, in the form of cigarettes, is the most addictive drug known. "You can become pharmacologically addicted to tobacco cigarettes in a matter of a few hours or a day or two. There is no other drug where the percentage of non-addicted users is so low."

A study released in England two years ago concluded that a teenager smoking more than one cigarette had only a 15% chance of remaining a non-smoker, he continued, yet "we not only tolerate tobacco but support the industry that purveys it with public funds."

Caffeine is another physically addicting drug causing problems like chronic urinary complaints in women, indigestion in men, and hand tremors, but "we've defined its drug nature out of existence."

Dr Weil noted that the drug education book *Teen Titans*, being promoted by Nancy Reagan, wife of US President Ronald Reagan, (**The Journal**, June 1983) contains only a passing reference to alcohol, and not a single comment on tobacco.

Real drug education, Dr Weil said, would put the dangers in perspective.

One point to be emphasized is it is less harmful to take opiate drugs — or any drugs — by mouth than to inject or smoke them, he said.

"When I was in medical school, the belief was that the most direct way to introduce a drug into your system was by intravenous injection," he said. "It's not. Smoking is much more direct. When you inject a drug into your vein, it is diluted by a fairly large volume of venous blood, first goes to the heart, then the lungs, then back to the heart, and, finally, to the brain.

"When you smoke a drug like nicotine, it goes directly into the lungs, into the heart, and then in a small quantity of arterial blood directly to the brain," he said.

"I would tell kids, 'if you're dying to know what tobacco is, what it does, chew it. That will tell you all you need to know about the drug, and you will have a chance to decide what you want to do about it. But if you smoke it, chances are you will be addicted before you know what happened to you.' "

MDs get blame for drug abuse

NEW YORK — An addictions expert told the Health and Addictions conference here that the medical profession has itself been directly responsible for most drug abuse during the past century.

Andrew Weil, MD, said the pattern was: a new prescription drug introduced as "non-addictive" was prescribed by physicians for complaints needing no medication.

Next, "the press" began to expose the abuses, legislative hearings were held, and doctors adopted the position: "It had nothing to do with us, nothing to do with our prescribing practices. This is an inherently bad drug that has no therapeutic uses, so take it away from us."

Dr Weil said finally, the drug under scrutiny was either outlawed altogether, or placed under severe medical restrictions, creating overnight a black market for people who first started using it on prescription.

He is the co-author of *Chocolate to Morphine — Understanding Mind-Active Drugs*.

Congress will await ADAMHA report

Controlled drinking probe deferred

TORONTO — United States Congressman Henry Waxman has declined to pursue for the time being a congressional investigation of controlled drinking work by psychologists Mark and Linda Sobell.

Ripley Forbes, an aide to the congressman, who is chairman of the subcommittee on health and the environment, told **The Journal** Congressman Waxman considers that it is inappropriate to proceed with any investigation until the current review by the US Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) is completed (**The Journal**, June 1983).

The request for the congressional hearing came from Irving Maltzman, PhD, a principal complainant against the Sobells' work, in a letter to the congressman late last year.

Dr Maltzman told **The Journal** he wanted the hearing because he considers past reviews, and the ongoing ADAMHA review, to be limited in scope.

He wants a full congressional hearing where the power to subpoena witnesses and evidence is used, and where participants are liable to penalties of perjury for providing false testimony.

He said the current ADAMHA review "has no power."A spokesman for the ADAMHA told **The Journal** the review is an ongoing process with no set completion date.

Also interested in a congressional hearing is David Evans, head of the Alcoholism and Drug Law Reform Committee of the American Bar Association (ABA).

Mr Evans told **The Journal**: "Our section in the ABA is the Individual Rights Section that deals primarily with civil liberties, and there have been some serious questions raised in my legal mind as to the use of human research subjects by the Sobells . . . . In the US, the normal standard of care for alcoholics is abstinence."

Meanwhile, in California, a group of patients trained to "control" their drinking by the Sobells in the early 1970s has initiated a lawsuit naming the County of Orange (where the Sobells conducted their research), the state of California, and the Sobells, as defendants.

Sympathetic prescribing part of multi-drug problem

HALIFAX — Many Nova Scotians with an alcohol abuse problem are also abusing prescription drugs.

Statistics showing admissions to the Halifax area detoxification program between September 1982 and September 1983 indicated that of the 899 patients in detox, 41% were also in trouble with other drugs, mainly benzodiazepines and sleeping pills.

"This is an astonishingly high ratio . . . perhaps the biggest problem we are seeing now in alcohol and drug abuse," John Savage, chairman of the Medical Society of Nova Scotia's alcohol and drug abuse committee told doctors attending the society's annual meeting here.

Following a recommendation from Dr Savage, members of the society passed a resolution urging doctors to look carefully at their prescribing habits with regard to sleeping pills and tranquillizers.

"We are part of the problem," Dr Savage told the meeting.

His report showed the current statistics contrasted with 10 years ago when the Halifax detox centre was opened. At that time, about 95% of patients admitted were treated for alcohol abuse only.

Dr Savage said the main problem involving people with multi-substance abuse is the "sympathetic prescribing by sympathetic physicians."

"Many of these patients must be known to physicians as alcoholics and what must be emphasized is that you cannot treat a drug dependency by using other drugs and running the risk of further dependencies," Dr Savage said.

Coming up in

The Journal

- **Reports from the United Nations Commission on Narcotic Drugs**
- **Gilbert on smoking in the workplace**

The edge is all

WASHINGTON — The "edge," real or imagined, is "all" to United States professional football players.

"And football players take drugs because they'll take anything that will give them the edge," says Carl Eller, who played for 15 years with the Minnesota Vikings and appeared in four Superbowl (championship) games.

Mr Eller said he took drugs because they made him feel good and feel he was able to solve his problems and fit in with friends: "chemicals for a real man." He was on a $2,000-a-day cocaine freebasing habit when his career ended.

Mr Eller has helped the US National Football League develop drug and alcohol programs for players, and a film has been produced about his addiction and rehabilitation called *My Fifth Superbowl — a story of winning*.

Mr Eller told a conference on drugs in industry here, sponsored by the American Council on Drug Education, that while players take drugs to get the supposed edge, they "hide behind the coat of professionalism" about the problems. Many players find it hard to adjust to life after football; it is even more traumatic if they have acquired a drug habit they can no longer afford, he said.

Harsh warning for players

WASHINGTON — Professional National Football League players in the United States are being warned by federal agents that illegal drug use and trafficking will be dealt with harshly.

The Justice Department is sending Federal Bureau of Investigation and Drug Enforcement Administration agents to each team to warn players. Coaches and officials are asked to withdraw during parts of these meetings.

The aim is to warn players about the impact on sport of bribery, gambling, and trafficking stemming from illegal drug use and dealing. Players are also being told they are role models for many young people and cannot expect special treatment.

NEWS

DWI countermeasures are goal

Citizen/scientist conflicts can be productive

TORONTO — Scientists, citizens, and the courts will probably go on arguing about the question of drinking and driving, says the executive director of the Traffic Injury Research Foundation (TIRF) in Ottawa.

"But that's not bad. It's constructive, because it says let's try to find a solution," says Herb Simpson, PhD.

"There have to be, and there will be, differences of opinion. As long as those differences are there, and as long as we try to work where possible from a sound empirical base, we will move forward."

For the moment, it's "difficult at times for the impartial observer to believe scientists and citizens actually share a common goal," Dr Simpson told a conference here on Drinking and Driving Countermeasures.

On the one hand, outraged citizens have largely generated the current groundswell of concern. At the same time, there is increasing conflict among agencies and organizations striving to deal with the issue.

Dr Simpson: "At the root of recent problems has been the clash of science and society. The demands for immediate action by impatient citizens have run headlong into a scientific wall — a veritable mountain of research." The disappointing message "seems to be that virtually everything has been tried to solve the problem, and nothing works."

He said at times it has appeared the research community "has enjoyed the opportunity to squash the suggestions of a segment of society it views as hysterical, ill-informed, and vindictively motivated."

On the other hand, "response to scientific findings by grassroots organizations has not been sympathetic."

Joan Marshman, PhD, president of Ontario's Addiction Research Foundation here, said research is a benefit only when it is used in developing policy, legislation, and community action.

From the community perspective, "research is a safeguard against investing our time, money, and energy in approaches that have previously been shown to lack effectiveness," she said.

Dr Marshman agreed it is not necessary to wait until all the research results are in before taking action against drinking and driving. But, "if we are committed to doing the best job possible . . . then we'll take care we don't become so protective and defensive about our chosen path that we are reluctant to change our course of action in the face of new research evidence."


Simpson


Marshman

Bringing scientists and the community closer together, however, is not the only answer.

Alan Donelson, PhD, senior research scientist at the TIRF, said there has been a tendency to rely heavily on the criminal justice system in seeking the solution. "When you've got a hammer, everything looks like a nail."

Richard Chaloner, director of Crown Attorneys for Ontario, said that for the first 15 of his 20 years as a crown attorney, he and his colleagues thought they were "out there alone" on the question of penalties for drinking drivers. "Generally, the community just didn't seem to give a damn.

"When I look around . . . I know we are no longer alone."

The conference brought together representatives of citizen action groups, research, law enforcement, and education; and local, regional, and provincial governments. It was designed to stimulate conversation and suggest steps for community-based action.

The next step, Dr Simpson told **The Journal**, will be to regionalize the action: to hold local meetings to select drinking and driving countermeasures tailored to each community.

Support is qualified for federal DWI proposals

OTTAWA — Tough new federal proposals to increase penalties for impaired driving seem to be receiving qualified support from many legal and safety professionals. But they feel more attention needs to be focused on public, police, and medical attitudes if changes are to be effective.

"Overall the package is excellent," commented Alan Donelson, PhD, senior research scientist with the Traffic Injury Research Foundation (TIRF) here. "I think it responds substantively to the public concern over the alcohol and drunken driving problem."

Winnipeg lawyer David Matas agreed, but: "It's partly an addictive problem which requires medical treatment. It's partly a social attitude and partly a police detection problem. All of these elements must now be moved forward and given greater attention."


Donelson

The proposals, to be tabled in the Commons as part of a series of Criminal Code amendments, were released in late December by Justice Minister Mark MacGuigan.

Highlights include an increase from $50 to $300 in the minimum fine for a first conviction, a rise to five years from two years in the maximum sentence for dangerous driving, and new penalties for dangerous or impaired driving causing death or bodily harm.

A justice department press release said 158,000 people were convicted of impaired driving in 1981.

The release also noted the need for "increased law enforcement and a widespread change in social attitudes toward the impaired driver."

Dr Donelson said that while he was pleased with the general thrust of the proposals, "now is the time to look at the more coordinated, interdepartmental programs that are also needed."

Mr Matas, sponsor of a resolution on impaired driving at the Canadian Bar Association annual meeting in August, 1983, also thought factors other than the actual legislation were important if the changes were to be effective.

He said passage of the amendments would be a good start; judicial interpretations of new sentences would nonetheless help determine how seriously they are taken.

"Minimums are more or less in line with average sentences right now," he said. "To make the whole thing effective, judges will have to take the signal of imposing harsher sentences."

Regina lawyer Morris Shumiatcher, however, described the proposals as "a kneejerk reaction . . . not a sound approach based on our knowledge of human nature and how we behave or misbehave."

Legal penalties presumed an awareness of consequences, "but the very act of drinking shuts out any consideration of consequences," Mr Shumiatcher said. "It's common wisdom that when a person embarks on a course of drinking he's not going to worry one iota about penalties. One reason people drink is so that they don't worry about anything."

Changes must start at the top

Faculty key to school's mood

TORONTO — Any improvement in the school environment has to begin at the top, says a United States consultant on alcohol and drug problems and former high school principal.

At his high school, William Manning, EdD, said he found "we could not hope to change the students until we changed the faculty."

During his last 30 months as a principal, he said, 303 students, 57 parents of students, and 37 teachers went into treatment for alcohol and drug problems.

He told the Ontario Secondary School Headmasters Conference here it is the responsibility of the teacher to establish an environment "that promotes what you want it to promote."

High school principals often believe, "if we admit we have a problem in our schools, it is a direct reflection on us as administrators," Dr Manning said. This fear can hamper efforts to recognize and deal with problems.

Dr Manning credits the alcohol and drug program established in his school in Minnesota in 1974 as "tremendously increasing the school's emotional environment.

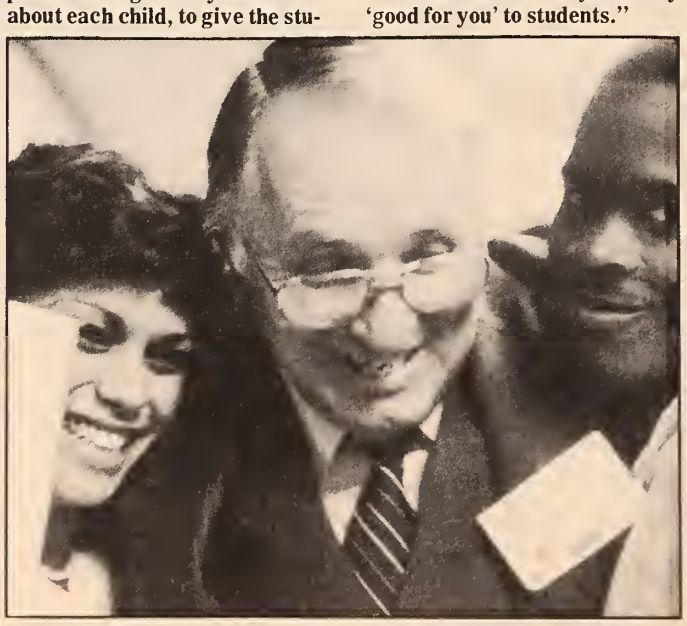
"The teachers became sober role models . . . and not once did we talk about abstinence or prohibition," he said.

Dr Manning said rules for absenteeism, drug use, vandalism, and general conduct were tightened at his school, but at the same time teachers began a program that recognized individual students.

He challenged principals and vice-principals to "reach out and touch" the students emotionally and physically, to find positive things to say and write about each child, to give the students room to be natural, and to include student input on decision making and planning.

"Each child has the right to come to school each day with the thought that he or she will be successful, regardless of mental ability or emotional stability," Dr Manning said. "Students (and teachers) have to find something good about the day.

"There are 52 ways to say 'good for you' to students."


Manning: 52 ways to say 'good for you' to students

Cdn traffic injury research honored, new study will examine role of drugs

OTTAWA — The Traffic Injury Research Foundation here (TIRF) has received the prestigious Widmark Award of the International Committee on Alcohol, Drugs, and Traffic Safety (ICADTS) for its work, including consultation with federal and provincial departments in the design of impaired driving programs.

The TIRF, founded two decades ago to research and analyze traffic accident problems, has a seven-province data base holding accident statistics dating back to 1967.

It has now begun a study to determine whether alcohol and drugs are to blame for all accidents in which they are involved. Senior research scientist Alan Donelson believes the research will cause waves in the addictions community.

"The project will definitely be breaking new ground — it's the first time the actual causal role of both alcohol and cannabis will be investigated," he said. The TIRF had until now been satisfied with "just detecting the presence of these drugs and not asking whether the accident would have occurred anyway."

BC school aims for A plus on anti-puffing project

By Eleanor LeBourdais

VERNON, BC — If its five-year pilot project is successful, Vernon Secondary School may be the first high school in North America with not one student smoker.

Principal Herb LaFontaine began the anti-puffing drive with collection of saliva samples from the entire student body. Laboratory analysis of the 1,200 samples for nicotine will determine what percentage of the students already are smokers. In 1988, another school-wide spit study will help to indicate how successful the anti-smoking program has been.

Mr LaFontaine says peer pressure, the main factor encouraging students to smoke, will also be employed to turn students away from tobacco. The primary target group will be those students who are just entering grade 8 (approximately 13 years old).

"When they start grade 8, only 10% to 15% smoke one cigarette a week," he estimates. "But at the end of that year it rises to 35% to 40%. They think it's the cool thing to do."

Older non-smoking students will be directly involved in the program as role models. Thirty non-smoking grade 12 students will act as role models, offering workshops and informal instructions, hints, and techniques on how not to start smoking, and how to go about quitting for those already hooked.

Mr LaFontaine says emphasis will be on promoting the positive image of the non-smoker. Over the five years, each new group of students will receive the message, with reinforcement programs in each successive grade until they themselves become the grade 12 non-smoking peer models.

Probably the most expensive part of the project is analyzing the saliva samples for nicotine content — as much as $3.25 per sample. However, the British Columbia ministry of health has agreed to fund that aspect of the program.

NEWS


Golobitsh

Stress: schoolwork, appearance

Stress, anxiety causative factors?

Girls catching up to boys in drug use

By Betsy Chambers

HALIFAX — Further investigation has been launched here into a relationship between drug use and stress, found in a study of the city's adolescent population.

Wayne Mitic, EdD, of Dalhousie University, and Brigitte Neumann, research coordinator for the Nova Scotia Commission on Drug Dependency, have already compiled data on stress and drinking in an analysis of alcohol consumption by Halifax youth in grades 7 to 12 where students are aged roughly between 11 and 19 years.

Now they are looking at the effect stress may have on the consumption of other drugs covered in their survey.

Preliminary findings in the 1983 study reveal that, based on results from a modified Straus-Bacon Problem Drinking Scale (1953), problem drinkers — those with three or more drinking-related problems — had significantly higher stress scores than their responsible-drinking or non-drinking counterparts.

The two groups were found to share the five most highly reported stress factors in a list of 12, although their ranking differed. The first two factors were common: school work and appearance.

For the non-problem group, relationships with parents and friends tied for third place while, for problem drinkers, money matters came third and relationships with parents fourth. In last place for the non-problem group was money; problem drinkers rated relationships with the opposite sex fifth.

The findings raised questions about relationships between stress and drinking but also required new interpretations of statistics on alcohol consumption by the city's youth.

On the face of it, drinking seemed to be going down with the percentages of youth that were drinking down in 1983 compared to 1979.

But, said Dr Mitic, "in previous years, we didn't apply that (modified Straus-Bacon) scale. We're hypothesizing (as a result of its use this time) that the drinking problem is severe. I mean when you get 32% of grade 12 students responding that they've had blackouts, for example, that to me is severity. That's problem drinking.

"But we didn't ask that question in previous surveys. Although the frequency of alcohol drinking has gone down to 68% (from 80% in 1979), those who are drinking are drinking to excessive levels."

Students stated whether their drinking was causing problems with school work, police, teachers, or family, or resulting in a drain on their money. They also noted whether they drank alone, before attending parties, or before breakfast, and if they had experienced blackouts, destroyed things, hurt others, or caused personal damage while under the influence of liquor.

Those with three or more problems on the scale accounted for only 6% of grade 7 students, but the percentage increased straight through to grade 12 where approximately 36% of all students were experiencing three or more problems with alcohol. In grade 12, there was a bigger portion of problem drinkers than abstainers.

The researchers note too that on questions relating to stress, girls consistently reported feelings of tension and anxiety more often than boys. The gap, however, only became particularly significant on stress factors concerning relationships with parents, siblings, themselves, friends of both sexes, or items of appearance and health.

The results have left researchers wondering if further investigation may lead to at least partial explanation of other findings in their 1983 survey.

For instance, while smoking among boys was found to have decreased to 28% from 42% of the survey group in 1979, there was no significant change among girls from the 44% noted in 1979.

Traditionally, girls are less likely than boys to use hallucinogens such as LSD, but, in the 1983 survey, females reported use of the drugs at the same levels as males. Use of amphetamines was also up among girls, with 15% reporting use in the six months prior to the survey, compared to 10.5% in 1979.

Dr Mitic: "What we are finding in the data now, is that females exhibit higher levels of stress and anxiety than males right across the board. In almost all items, females seem to be under more anxiety than their male counterparts, and that may explain part of the reason why more and more females are catching up to their male counterparts this time in drug use."

Preliminary data from the second phase of processing information from the 1983 survey indicate that among the female students surveyed, "those that are under stress have a tendency to use more drugs right across the board."

However, Dr Mitic said many questions are unanswered. Assuming the relationship between drug use and stress can be substantiated, it is uncertain which is the causative factor. Female respondents may also indicate they feel more stress because they may be more sensitive or because males are too shy to admit the degree of their stress-related problems.

But the researchers are confident about the reliability of their data. An inbuilt "truth factor" was included on a random cluster sample of 88 classes, consisting of 25% of the grades 7 to 12 students. Each was asked if he had used a fictitious drug within the six months before the survey. Those who said yes had their questionnaires discarded by the researchers.

Teens and adults choose different types of drugs

CHICAGO — Adolescent drug abusers are more likely to use amphetamines, hallucinogens, and marijuana, while adults are more probably on cocaine, heroin, and street methadone, says a new study of patterns of substance abuse among clients in a drug program here.

Investigators at Gateway Foundation also examined the consequences of abuse and family and related problems in 220 adolescents and 668 adults. The study evaluated their history, psychological symptoms checklist, scales measuring treatment goals, and self-esteem ratings.

However, the authors, in *Clinical Research Notes*, caution that while their findings are important in understanding differences between adolescent and adult abusers, figures are not applicable to the general population of drug and alcohol abusers.

Multiple substance abuse develops more rapidly among adolescents than among adult addicts, they found. And adolescents are more likely to be using several substances at the same time. Heavy drinking was also more common with adolescents, 66% having had a period of heavy drinking in their lives compared with only 50% of the adults.

Adolescents reported more violence in their homes while growing up, compared to the adults. The figure was 57% compared to 46% for adults. Among the adolescents, 65% reported drug abuse in their families compared to 46% adults.

In other findings, both groups reported serious or chronic illness in their families. Furthermore, 48% of adolescents and 28% of adults had received treatment for mental or emotional problems, apart from their drug abuse or alcoholism therapy.

Dial-a-(drug) fact tapes on call province-wide

TORONTO — Response to test-marketing of taped telephone messages on alcohol and drugs has prompted an early expansion of the system to provide access throughout Ontario.

The Addiction Research Foundation's (ARF) Dial-a-Fact program, a series of 41 taped, factual messages, started in Toronto on a trial basis in October 1983 and is now receiving about 1,000 calls a month.

Starting this month, the program will be available to other Ontario residents with the installation of a toll-free number.

Henry Schankula, director of education resources at the ARF, said the service was expanded faster than anticipated because of demand beyond the test-market area.

Other provinces, including Alberta, New Brunswick, and Nova Scotia, are also indicating an interest in the service, he said.

Dial-a-Fact's messages on alcohol and drugs range from basic facts about various drugs and how they affect the user, through discussion of long-term use, to effects on the family and legal issues.

Titles include — Facts on alcohol: identifying alcoholism; Alcoholism and the family: the children; Barbiturates and other sleeping pills: what they are and how they affect users; Too much caffeine? what it is and how it affects users; My teenager may have a drug problem: sharing your concerns with your child; and Hazards of street drug use: fakes, substitutes, and street doses.

Mr Schankula said the system was developed in response to a growing demand for information. The messages are an efficient way of handling repetitive questions and, at the same time, offer the caller confidentiality and the opportunity to hear the information repeated several times. Transcripts of the messages are also available.

Brochures cataloguing the tapes and topics have been printed with the assistance of the Junior League of Toronto for distribution to callers, social service agencies, health centres, libraries, etc.

BMA slams indirect tobacco promo

By Thomas Land

LONDON — The British Medical Association (BMA) has called for strict legal controls on the indirect advertising of tobacco products — especially those which could influence young people to smoke.

The association is concerned the tobacco companies are breaching the spirit of the ethical code of Britain's Advertising Standard Authority (ASA) on cigarette promotion by associating the colors and logos of certain brands with sporting events and other activities which, by implication, depict smoking in a glamorous light.

A BMA official said: "The tobacco companies are flouting the spirit of the code by using all the images they would have once applied to the direct sale of cigarettes to the indirect, subconscious promotion of tobacco products."

The ASA's cigarette code specifically bans advertisements which depict smoking in a manly, sexy light or which show female smokers as more glamorous and independent than non-smoking women. But it actually excludes from its provisions cigarette names and design styles which are used to promote non-tobacco products and activities.

The BMA's call for a ban on indirect advertising follows the publication of a government report which shows that almost one in five children between the ages of 11 and 16 years smoke. More than 60% of those who were regular smokers thought they would continue the habit after leaving school.

Significantly, the BMA emphasizes, recent research has shown teenage smokers tend to consume cigarette brands most often seen in television sports promotion.

"The tobacco companies have had to find other methods of advertising their products over the last few years as more and more countries ban tobacco promotions," says the BMA.

"Young adults are the main target of the companies. They usually have the highest disposable income and, if they adopt the smoking habit early, they could remain lifelong consumers. It is this age group that most readily responds to the glamor images" presented by some cigarette brands.

The British code of advertising practice, as amended early in 1983, states "advertisements should not seek to encourage people, particularly the young, to start smoking or, if they are already smokers, to increase their levels of smoking or to smoke to excess, and they should not exploit those who are especially vulnerable, in particular young people and those who suffer from any physical, mental, or social handicap."

But it also states advertisements for other products which contain the names of cigarette brands, or which incorporate elements of the design of branded cigarettes, are not regarded as cigarette advertisements.

The BMA charges that the tobacco industry has "latched on to this loophole" and that, as a result, the spirit of the advertising code is "going up in flames." It prescribes urgent new advertising controls.

Pharmacists tackling drug abuse

WASHINGTON — A pharmacists-against-drug-abuse campaign is to be launched nationwide in the United States after a successful tryout in seven New England states.

Jack O'Brien, president of McNeil Pharmaceuticals and a leader in setting up the voluntary program, said more than a million brochures had been distributed in New England in 1983. Actor Michael Landon made a 30-second television and radio spot for the campaign.

The aim of the campaign is to provide pharmacists with information about drug abuse and allow them to be a resource for parents and teenagers, as well as a referral service for agencies that can help.

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Letters to the Editor

Gun/driver controls outweigh age issue

Most (United States) legislators and other state government officials pretend to believe that establishing or maintaining a legal age for the consumption of alcohol at 21 years will control drinking by those under that age level. Yet Mr Hedin, in his letter to **The Journal** (Dec 1983), states that the median beginning drinking age of the average North Dakotan is now below 12 years of age. In spite of these data, he maintains the position that the legal age for consumption of alcohol should be at least 21, and he prefers 26.

How can anyone who knows anything about the alcohol problems of preteen and teenagers persist in deluding themselves that legal statutes have anything to do with who uses alcohol? People who work directly with young people under 21 (Mr Hedin included) know that alcohol is readily available to all age classes of the population, regardless of state statutes. The only thing the law does is define whether use of alcohol is illegal or legal. Teenagers have contempt for a law that excludes them from this single privilege of adulthood when they have been given all of the other rights accruing to adult status at 18.

In most states in the US, a child of 12 years may secure a licence to use a gun when accompanied by an adult; and it is rare to control use of a gun except for hunting wild game. States establish 16 or younger as the age at which people can be licensed to drive an automobile. We legalize the possession of two most lethal weapons at a ridiculous age, and then try to prevent their misuse by enacting unenforceable laws restricting the use of alcohol, which only compounds the dangers from other lethal devices.

We will never solve the problems relating to the misuse of alcohol by ignoring the basic issues. Maturity is not a factor of age. Until we can find an adequate measure of that quality upon which to deny access to lethal weapons or the only dangerous drug (alcohol) that is legal without a prescription, we are tilting at windmills when we establish laws based on age as the sole criterion for maturity.

If it is our purpose to reduce the level of unnecessary deaths caused by any source, then control efforts must focus on the licensing of lethal weapons themselves, and not alcohol, which is only a part of the total problem. People die because of sober drivers, as well as guns in the hands of irresponsible abstainers. Until we recognize the real problem, any efforts to control it will go for naught.

Jack C. Buckle
Dean of Student Services
Lycoming College
Williamsport, Penn

'Unfair accusations'

NORML opposes teen pot use

Your article, Pro-pot lobby is wrong on facts, politics: DuPont, (**The Journal**, Dec 1983) contained many false accusations regarding the National Organization for the Reform of Marijuana Laws (NORML).

We are not pro-pot. The NORML favors active discouragement and is opposed to adolescent marijuana use. However, we believe coercion through criminal law is not as effective as public information and education.

The marijuana law reform issue is not a "relic of the 60s," as Dr Robert DuPont was quoted as saying. Ninety per cent of the 30 million annual marijuana smokers in the United States are more than 18 years old; the fastest growing age group is older than 30. These are often young professionals who are becoming more politically active and will soon be in a position to change their criminal status.

We are currently living through the last gasps of marijuana prohibition. Extraordinary law enforcement and public opinion efforts are being undertaken to save the failed marijuana policy. Soon, legalization will become the only sensible solution.

The article's claim that marijuana decriminalization is dead is only partially true. The US has almost completely decriminalized possession. Eleven states, encompassing one-third of the population, have enacted decriminalization laws, and 29 other states have adopted a pseudo-decriminalization whereby marijuana offenders are put on probation with both arrest and conviction records erased after probation is completed.

The article was critical of the NORML for adopting "medical and environmental guises." In reality, the NORML has opposed paraquat since the mid-70s. The fact that established environmental groups like the Sierra Club, Friends of the Earth, and the National Coalition Against the Misuse of Pesticides joined us in challenging its use shows paraquat causes serious environmental problems. Indeed a US District Court has put a stop to its use in eradicating marijuana growing in the US.

The NORML has been litigating the legality of marijuana's medical prohibition for 10 years; three times the US Court of Appeals has ruled in our favor. However, the NORML cannot take all the credit on the medical issue. The thousands of seriously ill individuals who need marijuana for therapeutic uses should be given credit for laws passed in 33 states and a bill before Congress (House Resolution 2282) which would legalize the limited medical use of marijuana.

While the NORML is concerned with these and other policy issues, our primary concern continues to be ending marijuana prohibition. Prohibition glamorizes marijuana and encourages adolescent abuse; it creates a huge black market that sustains organized and unorganized crime and deprives us of tens of billions of tax revenue dollars each year; it creates a massive law enforcement bureaucracy which wastes billions of dollars and erodes civil liberties; and, most importantly, it fails to control marijuana use — since 1970, annual use has tripled from 11 million people to more than 30 million, and marijuana has become the leading cash crop in the US.

If we want to bring this out-of-control situation under control, we should learn from the mistakes of the past and change our policy to one of regulation and taxation. Age restrictions, potency labelling, health warnings, and purity controls, with sales by licensed retailers, will protect public health better than prohibition.

Kevin Zeese
National Director
NORML
Washington, DC

CAF workshop a team effort chairman says

Thank you for the article, Youth and drugs is focus of two-day CAF workshop, (**The Journal**, Dec 1983).

It should be noted, however, that this workshop is being co-sponsored by the CAF (Canadian Addictions Foundation) special interest group on program evaluation, the Addiction Research Foundation of Ontario, and the Health Promotion Directorate of Health and Welfare Canada. In particular, the contributions of Irving Rootman, Bill Graham, Neville Layne, Reg Smart, and Bill Gilliland to the planning should be noted.

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VIEWS ON THE TREATMENT OF ALCOHOL ABUSE

The Behaviorists

Abstinence as the only feasible treatment goal for alcoholics has been challenged for two decades by researchers and others who consider that problem drinkers can be trained to moderate drinking to a "safe" level.

And the debate continues.

Traditionalists say alcoholism is a disease controllable only by total abstinence; behaviorists point to studies indicating favorable outcomes for problem drinkers, given a treatment goal of moderation.

At the recent four-day meeting in Washington, DC, of the Association for the Advancement of Behavior Therapy, an international panel of behaviorists discussed the issue. Their topic: Abstinence and Controlled Drinking: Alternative Treatment Goals for Alcoholism and Problem Drinking?

Contributing editor Karin Maltby attended for **The Journal**. Following are excerpts from the discussion.


Maltby

Chairman was Alan Marlatt, PhD, professor of psychology at the University of Washington, Seattle, and a researcher in controlled drinking.


Marlatt

He said: "When abstinence is a goal for problem drinkers, a significant proportion engage in moderate drinking even though they haven't been trained in that specific procedure. And, at the same time, many controlled drinking studies where people are taught these particular skills — many of these patients end up abstaining. And many go back and forth between the two."

Dr Marlatt said that, in some ways, asking a patient to stop is "obviously a form of control in its own right." He said many people fail to present themselves for treatment because of the stigma associated with the label 'alcoholic.'

However, if clients are asked whether they have a drinking problem "that is much more acceptable than saying 'admit that you are an alcoholic and that you are powerless.' " Dr Marlatt said while this particular approach works for some, "what about all the rest of the people?"


Miller

William Miller, PhD, psychologist, department of psychology, University of New Mexico, Albuquerque: "Although behavioral methods involving controlled drinking are, in fact, experimental, they are better supported than any other single approach to the treatment of alcoholism that exists at the present time.

"Critics of controlled drinking have assumed that abstinence is a safe and effective alternative; we do not have adequate proof of that. I think it's quite unfair to criticize the safety of moderation while assuming, without data, that abstinence methods are effective.

"We need to understand what method is best for what client with what social problem and offered by what kind of therapist."

Dr Miller began controlled drinking research in 1974 and has conducted seven clinical trials since then with about 300 patients. The patients are primarily non-*gamma* alcoholics, people not physically dependent on alcohol.

"Despite the fact that we tried to eliminate severely-addicted or dependent people, our clients would certainly have met the criteria for alcoholism by virtue of any definition that exists, in part because (in the United States) we use a very generic, inclusive definition of alcoholism. So, they're problem drinkers, and that's probably the best way to describe them.

"We have three clinics doing controlled drinking treatment in Albuquerque, two of which advertise that fact in the Yellow Pages, which is genuinely unusual. We offer this treatment to volunteers, and we receive referrals from the NCA (National Council on Alcoholism) office in Albuquerque. We've done a lot to build bridges with the traditional abstinence community.

"We have found about two-thirds favorable outcomes. This includes some abstinent cases, some people fully-controlled, and some substantially reduced — but not quite so much as we might like at one-year follow-up.

"The two-thirds favorable outcome is, I think, a fair, conservative summary that includes all our lost and drop-out cases counted as unsuccessful. That's been consistent across other clinics. Very similar (outcomes) have been found, using similar treatment techniques, by Alden in British Columbia, Pomerleau in Philadelphia, Vogler in Los Angeles, and Sanchez-Craig in Toronto.

"I might contrast this with the figure that is commonly quoted that less than 10% of people can succeed in controlled drinking. That figure is based on studies in which people were treated with a goal of abstinence and given absolutely no help in controlling their drinking. In fact, they were told they would not be able to do so.

"We have also found that minimal interventions are just as effective as more extensive interventions. We compared 18 weeks and six weeks of training, and a self-help manual with a therapist-administered program.

"If you have a low-empathy therapist you're better off going home with a manual and never seeing a therapist.

"We have had about 15% of abstainers in our program over a two-year follow-up — that is 15% tried controlled drinking and then stopped. In our seven or eight years of research we have had no relapses in those abstainers. After being treated in controlled drinking — if they do drink they drink very moderately, typically for a short period of time, and then go back to abstinence. This is in direct contradiction to what happens normally with a period of abstinence — a large relapse that extends for a span of time and then back to abstinence. What we seem to have done with these people is to squash down the relapse to very moderate levels.

"We have also found that a person who has succeeded in controlled drinking is very predictable, tends to be a less severe problem drinker, doesn't regard himself as an alcoholic, and has less family history of alcoholism. The person who succeeds in abstinence tends to be more addicted, more severe, regards himself as an alcoholic, and has more relatives who are diagnosed as alcoholics."

Responding to a question from Dr Marlatt — is controlled drinking only an appropriate treatment goal for problem drinkers? — Dr Miller said: "As severity of dependence increases, the probability of successful controlled drinking goes down, and the probability of maintaining successful abstinence goes up.

"It's very tempting in the US to say controlled drinking for problem drinkers, but real alcoholics have to abstain. I confess that I have used that language to increase the acceptance of controlled drinking programs at the prevention stage, and I've been quite successful. But, at least in the interim period, I'm much more interested in looking for ways to find harmony between the substantial, existing alcohol (treatment) community, and new approaches that are understandably difficult to accept."

Martha Sanchez-Craig, PhD, psychologist, behavioral research, Clinical Institute, Addiction Research Foundation (ARF), Toronto, outlined a study at the ARF of early-stage problem drinkers. "The conclusions that we drew from the study were that controlled drinking was a more suitable goal. It was more acceptable to the client, and controlled drinking clients drank less during treatment. Most abstinent clients developed moderate drinking patterns on their own, and abstinent clients received extra counselling from the therapists (**The Journal**, April 1983).

"The clients were socially stable, they were healthy, fully employed, presenting for treatment for the first time. At intake, they reported an average weekly consumption of 50 drinks.

"The design of the study involved random assignment to a single program differing only in treatment goal. Half of the clients were assigned to a goal of abstinence and the other half to a goal of moderation. They weren't aware of the alternative goal.

"All of the clients were treated individually on an outpatient basis in weekly sessions. Both groups received treatment involving self-monitoring of drinking behavior and frequency, identification of high-risk situations, and development of cognitive and behavioral coping strategies. For the controlled drinking clients, there was specific training in techniques, for achieving moderation," Dr Sanchez-Craig said.


Sanchez-Craig

"The mean weekly consumption (for both groups) went from an average of 50 drinks per week to about 13 drinks per week. In summary, the controlled drinking option offers to clients a range of personal objectives which do not suit abstinence."


Heather

Nick Heather, PhD, department of psychology, the University of Dundee, Dundee, Scotland: "I agree that the optimal application of controlled drinking methods is in the area of fairly brief, inexpensive, minimal interventions with problem drinkers with low or minimal levels of dependence.

"However, I notice a regrettable tendency to conclude that controlled drinking is only suitable for such people and is not suitable for another whole class or category which is called addictive alcoholics — gamma alcoholics. This kind of conclusion plays into the hands of the abstinence lobby and can be used by them to say, 'Well, we were right all along.'

"I would reject any attempt to categorize problem drinkers into addictive or non-addictive . . . The Sobells' work, which has not been discredited, shows that gamma alcoholics treated by controlled drinking methods do better than control groups given abstinence (as a goal).

"Dependence is on a continuum . . . A review of studies which we conducted shows there's no upper limit to the possibility of control. It doesn't mean to say you should recommend it for all people, but it shows there's no theoretical upper limit.

"We know surely that physical dependence is a completely inadequate explanation of dependent drinking and of dependence to other substances.

"Low dependence (as classified in the 1976 Rand Corporation report) was defined to include nine episodes in the past month, of things like shakes, morning tremors, loss of control, blackouts, missing meals, drinking continuously for 12 hours. You can have nine episodes of that and be classified as low-dependent in the Rand report. Now, you might think that that is some significant degree of physical dependence and you would still get a much better prognosis than non-problem drinkers treated with abstinence.

"Marriage, age, and employment (status) are also important. There are also concerns to consider like a client's wishes, social support for or against controlled drinking, past history, and a client's beliefs about the nature of problem drinking."

In a discussion period, Dr Heather said, "it's time we went on the offensive.

"This abstinence/controlled drinking debate happened also 150 years ago in the early days of the temperance movement when there was a big debate between moderationists and the abstinence-only people.

"We've had to adopt a defensive pattern in view of this tremendous ideological support for the other side, and also in view of the tremendous double standard which permeates. It seems to suggest that it's very dangerous to recommend controlled drinking to people because they might relapse without recognizing that they relapse from abstinence at least as much, if not more, under certain conditions.

"It's about time we tried to legitimize controlled drinking publicly."

VIEWS ON THE TREATMENT OF ALCOHOL ABUSE

The Behaviorists

Fanny Duckert, PhD, research psychologist, National Institute for Alcohol Research, Oslo, Norway: "I don't like the term controlled drinking because it is very often misunderstood and gives the impression that abstinence is not allowed — that either you have to decide to be abstinent or you can have this magic controlled drinking. I think there is the belief there is some kind of immorality in people working with controlled training in that they are tempting those poor alcoholics into drinking again.

"It is easier to agree (with patients) upon a goal that states we want to have a reduction in alcohol consumption, and we want to have a reduction in problems connected with drinking, and we can have this reduction in different ways. A person could drink just as often, for instance, but reduce the amount at each (episode).

"To me there is not a dramatic difference between not drinking altogether, or reducing alcohol consumption to a level that's not going to create problems. And what is most important, in my experience, is that people needing abstinence most are very often the ones who are least able to accomplish abstinence.

"If we separate controlled training as a treatment technique, then it's also much easier to see that this technique is very useful for people who are going to be abstinent. You have to work on training, on preventing drinking urges. You have to train people to resist pressure to drink, you have to train people in being able to stop again if they have a slip, and you have to help people to prevent or reduce the number of drinking binges. We know that a patient, sooner or later, will have a drinking binge, and I think it's very important to help (the patient) make these events less traumatic and less problematic than before.

"I let my clients decide for themselves because they're the people who are really the experts. I spend a lot of time with them discussing their problems, and solutions. And finally, what kind of techniques can we help you with so you can succeed? That means that I have patients who are going to be abstinent the rest of their lives, some want to be abstinent for shorter periods, and other people want other kinds of reductions or changes in their drinking patterns. Each person is looked upon as a unique individual with unique goals. There is no temptation to extol drinking to people who have decided that they want to be abstinent.

"It's dangerous to put people into boxes, saying that for a certain group only (one) solution is possible.

"The most important tool that we have is our patients' motivation, a willingness to investigate and invest in reaching their own goals."


Duckert

Dr Duckert is now conducting a controlled comparison between minimal treatment and more intensive group training, with both approaches based on the treatment goal of reduction in drinking. Preliminary results indicate men receive no further benefit from training sessions added to a single, intensive consultation with a therapist. However, results for women are the opposite.

Dr Duckert elaborated in response to a question: "It turned out that 73% of the men reduced their drinking down to a mean of half the amount they were drinking before and during the project. For women getting one consultation, a little more than half of them reduced their drinking, but only by about one-fifth less than previously. However, of the women getting group training — 90% reduced their drinking down to one-third of their earlier consumption at three-months follow-up."


M. Sobell

Mark Sobell, PhD, research scientist, Clinical Institute, ARF, Toronto: "The very conduct of controlled drinking research is in peril, at least in the US. If we're to continue to progress, the future treatment of alcohol problems must be guided by rationality and empirical knowledge.

"Although the challenge to traditional ideas has occurred on many fronts, the focal issue of the conflict has been treatment goals . . . Recently, the focus of the controversy has changed. At a scientific level, a paradigm shift has already occurred. The present controversy really concerns what to do with the new knowledge.

"If one examines the scientific literature over the past few decades, using controlled drinking as a focal issue, it becomes apparent the paradigm shift has occurred. For years, reports of controlled drinking outcomes were very infrequent in the literature and were disregarded by most in the field as spurious anomalies or as artifacts of poor diagnostic classifications.

"The normal science, until recently, therefore, was that people with alcohol problems could only recover through abstinence, and that is the view to which most scientists subscribe."

Dr Sobell said controlled drinking outcomes are being reported with ever-increasing frequency — even in abstinence-oriented programs. "Now this finding is even more striking in light of the fact that in many of the studies the subjects' self-reports were confirmed by significant others.

"The unanimity of even abstinence-oriented studies in reporting such outcomes suggests that the phenomenon is more prevalent than some of us support.

"We conclude, therefore, that at the level of research a scientific revolution has occurred, but, as with all fields, the application of scientific knowledge is governed by a rather different set of factors than govern the conduct of research."

In a later discussion, Dr Sobell said change will come about slowly, and it would be "unwise for us to nab horses, grab our lances, and go trotting off into battle because most of us who are involved in this are used to a different trade in science and perhaps clinical practice.

"Traditional alcoholism treatment is a very large industry, certainly in the US; there are many vested interests . . . The data aren't the only things that happen to go into decisions about what reaches the public and what is favored by the public. So I think that things will be slowly changing; I think it is inevitable, but I think we have to be very careful about what we do to facilitate the change because we can make a lot of problems for ourselves as well."

Linda Sobell, PhD, research scientist, Clinical Institute, ARF, Toronto: "We are fighting about which set of ideas will guide future research and treatment. We're engaged in the struggle because we're committed to this field and because the empirical body of knowledge which has evolved suggests different directions and conceptualizations for treatment and research from that firmly espoused by traditionalists.

"The scientific level of the debate is all but over. Alternative beneficial outcomes do occur and are being reported with ever-increasing frequency in the literature — even in the abstinence-oriented programs. What we're fighting for now is acceptance at the service-delivery level and the opportunity to do the research to further advance this field.

"Clearly, it is now acceptable to report non-abstinent outcomes but further change is necessary if any of us are ever to witness long-term, beneficial, enduring outcomes.

"Can the competing camps ever work together? We have different expectations; we have different approaches to the problem. Simply put, it is unrealistic to think that staunch traditionalists will readily accept anything other than abstinence from beginning to end.

"But in retrospect, I think . . . we should have asked many, many years ago the very same questions that have been asked of us. What of abstinence? Does it work? For how long? For whom? Under what conditions? And does it work any better than the other goal? Or no treatment at all?


L. Sobell

"It is time for everyone in the alcohol field — scientists, clinicians, and traditionalists alike — to come to grips with two very stark realities.

"The first thing we must recognize is that even good outcomes are frequently interrupted by relapses. We must learn to help our clients constructively deal with such events. The second thing that we must acknowledge is that at this time, no one has enduring answers."


Peele

Stanton Peele PhD, psychologist and author, Morristown, New Jersey was a guest discussant although not a member of the panel: "Problem drinkers are drinking to mediate their experience with life, and their patterns of drinking shift with short- and long-term needs. They are actually self-regulating organisms, however inexact and dysfunctional they at some times seem to be.

"A particular strategy is exactly as effective as a client makes it, and as well as it fits into his internal needs and his view of himself and his view of his situation. We may hope to inspire that client and hope to respond to his or her needs. But I think it may be a little grandiose for us to claim any larger role for ourselves in what happens to this person."

Dr Peele talked about the "silent majority:" alcoholics, and smokers, who never seek therapy. Between 1965 and 1975, in the US, he said, 20,000,000 smokers quit on their own. And the 1982 US Surgeon-General's report notes that "outcomes are sometimes better with less rather than more therapeutic contact.

"I think there's something similar about asking a behavior therapist to do something and asking God, because both of them always tell you the hardest way to do it."

In a 30-year follow-up of 110 alcohol abusers, George Vaillant reported that 20% of this group were drinking moderately while 34% were abstaining. Dr Peele: "Hardly any of the subjects underwent formal therapy . . . The 20% doing controlled drinking obviously were not being supported by Alcoholics Anonymous (AA) and 3% of the abstainers did not have contact with AA.

"(Some) people may not be comfortable with a goal of abstinence and that is why they're refusing to turn themselves over to therapy because they can anticipate what they're going to hear there. They nod their heads in agreement about the value of abstinence therapy, and they go out and live their lives and they project their own desires and values. They do not like to call themselves alcoholics."

Dr Peele mentioned "individual moments of truth" — when drinkers decide to quit following some upheaval or revelation in their lives. "(They may) go right on drinking. However, I think they are telling us something very important about themselves and their values when they describe where they made strong a resolution to stop drinking. These are situations which are very significant to the individual and yet which have no objective correlate — a reminder of just how important subjective assessment of self is.

"The key ingredient to making anything work is a person identifying with the goals of therapy and really wanting to do something about them." Dr Peele referred to a study by Dr Heather: "Your belief about whether you're an alcoholic, or how physically dependent you are, is far more important in predicting whether you will relapse — than any attempt to objectively assess your level of dependence."

(Ed Note: K. Gunnar Gotestam, MD, PhD, department of psychiatry, University of Trondheim, Norway, spoke very briefly at the discussion before leaving to fly home.)

NZ launches attack on way of life — drinking

By Tony Garnier

WELLINGTON, NZ — New Zealand's Alcoholic Liquor Advisory Council (ALAC) plans to attack what seems to be a key feature of the New Zealand way of life — drinking.

The move was announced by the ALAC chairman, John Robertson, a former secretary-general of the justice department, who said he would get the main proposals into practice within two years.

Proposals include bringing liquor prices into line with the consumer price index and taxing absolute alcohol content.

At least 16 government departments deal with alcohol, including health, social welfare, transport, education, labor (industrial safety), treasury, agriculture and fisheries, and trade and industry.

Planners suggest that while the onus for lowering alcohol consumption is on the individual, government departments could help by looking harder at factors such as pricing, drinking conditions, distribution, and outlets.

Statistics cited in the policy summary led the ALAC to conclude that alcohol use/abuse is central to New Zealand life.

The phrase: "How about a drink?" is almost a national greeting.

This concern about misuse has been ignored, despite dangerous trends revealed by the few statistics available, including:

- In the last 20 years alcoholic psychosis and alcoholism increased 570%; deaths from liver cirrhosis went up 263%; and, in 1980, alcohol was responsible for one-fifth of psychiatric hospital admissions.
- Drunken and disorderly offences rose 74% between 1978 and 1980; a study of convicted violent offenders indicated 84% had been drinking before the offence; and alcohol was involved in 25% to 27% of road accidents in which drivers were admitted to hospital.
- Alcohol misuse causes serious diseases of the nervous system, heart, liver, pancreas, and other organs.
- There is a relationship between alcohol and industrial accidents, domestic violence, child abuse, absenteeism, marriage breakdowns, and house fires.

The key assumption on which the council bases most of its policy package is that "to reduce society's alcohol problems we must reduce society's alcohol consumption. There is certainly a strong relationship between per capita consumption and alcohol-related problems."

The package calls for action from the government, the community, and the liquor industry.

A coordinated government policy should "balance the economic benefits of a strong liquor industry against the public health problems linked to alcohol."

The council (established by act of parliament in 1976 to promote moderation in the use of alcohol) has requested the government to:

- Coordinate under a cabinet committee the activities of departments which work with alcohol in some way.
- Prohibit any increase of liquor outlets, or of sale or drinking hours.
- Introduce a tax incentive/disincentive regime covering alcohol production and distribution, and regulate exports and imports.
- Initiate a more vigorous community awareness program, including providing all members of parliament with regular information showing links between consumption patterns and alcohol-related problems.

Policy objectives with the liquor industry include encouraging it to restructure operations and drinking environments to discourage heavy drinking, to move gradually away from encouraging the public to buy in bulk, and to use messages of moderation in advertising and marketing.

The ALAC also promises to mount an advertising campaign aimed at countering alcohol's glamorous image.

Mr Robertson said under-age drinkers, who were getting access to liquor as easily as those of legal drinking age, were of particular concern.

He believed New Zealand had a unique opportunity. "We are a small country. It isn't impossible to get together to make sure we have a moderate drinking environment."

Med journal red-faced over ad

AUCKLAND, NZ — The *New Zealand Medical Journal* has apologized after being taken to task for publishing a wine advertisement.

"Grogwatch," a ginger group dedicated to reducing alcoholism, called the publication hypocritical for promoting health, on the one hand, and advertising alcohol on the other.

But the full-page display ad for a wine merchant should never have appeared and would not be repeated, said journal advertising manager Eileen MacArthur. The offending copy was accepted sight-unseen.

Glengarry Wines of Auckland offered readers a chance to buy wines from Europe and North America, as well as locally- and Australian-made products "at less than wholesale price."

Company manager Martin Jakicevich said wine has always been a "medical drink," beneficial to the body if taken in moderation, or with food.

In fact, he thought it would be a good idea if doctors started prescribing wine since it was full of iron and calcium.

The journal is published by the New Zealand Medical Association, to which most of the country's doctors belong.

Bromocriptine aids in checking withdrawal

OSLO — The drug bromocriptine (Parlodel), which enhances the action of the neurotransmitter, dopamine, has been found helpful in moderating alcohol withdrawal symptoms, say workers at the Blue Cross Clinic in Norway.

Dr Victor Borg *et al* report (*Acta Psychiatrica Scandinavica*, 1983, 68, 100) they administered either bromocriptine or placebo to 50 alcoholics to determine whether the agent would improve the rate of abstinence.

After six months, the drug-treated group responded better than the controls in several ways: they seemed better adjusted and used fewer drugs; they were more highly motivated and had greater insight into their problems; their craving for alcohol was significantly reduced.

The treated group also had fewer neurotic and depressive reactions and consumed far less alcohol during the six-month follow-up than the controls. Relatively few side effects were noted.

The authors are unsure of the mechanism that causes these desirable results, though they note that bromocriptine's neuropharmacological action — it also affects another neurotransmitter, noradrenalin — may be associated with the changes in alcohol abuse shown.

Western drinking problems catching up with Hong Kong

HONG KONG — Western drinking habits, and beverages like brandy and beer, may be causing serious problems here, says a recently published study.

Social costs of alcoholism are considerably less in Hong Kong than in other industrial countries, but alcohol abuse causes difficulties in individuals. Moreover, a significant number of Hong Kong industrial and construction workers drink to the point where efficiency and safety are threatened.

These findings came in the four-part, *Exploratory Study on Alcohol Abuse in Hong Kong: Myth, Fact, and Unresolved Questions*, by the Hong Kong Council of Social Service.

Included were a survey of employers to see how alcohol abuse affected absenteeism and productivity; a look at alcohol-related problems among caseloads of family service agencies; a study of blood alcohol levels in workers seeking treatment in a casualty hospital after industrial injury; and a constituent examination of relationships between alcohol use and narcotic addiction and rehabilitation.

It has long been assumed that while the Chinese may drink reasonably large amounts, they do not become alcoholics.

But, there have been recent warnings that while consumption of traditional Chinese wines is fairly constant, per capita consumption of Western-type beverages, especially brandy and beer, has gone up significantly. The per capita consumption of beer, for example, rose 162% between 1970 and 1980.

The fear is that Hong Kong may be adopting Western drinking institutions and habits. Similar developments in Japan led to rises in alcoholism and alcohol-related problems.

It was found that the social and economic costs of alcohol abuse are not unduly high. Only 3.5% of the more than 1,000 industrial and commercial employers surveyed felt alcohol abuse had contributed to absenteeism or inefficiency, although 18% felt it was becoming more of a problem.

Similarly, for family service agencies, alcohol-related problems were not major factors contributing to family dysfunction. However, 48.9% of the caseworkers surveyed knew of at least one instance in which alcohol was a factor, and 26% felt problem drinking was an increasing burden on financial and counselling services.

Interestingly, the third research section examining blood alcohol levels in patients suffering industrial accidents showed only 8% of the injured workers admitted to having taken alcohol during the 24-hour period, while no less than 43% were actually found to have done so.

In 7%, blood alcohol levels were above the 0.05% level accepted in some countries as the point at which it is illegal or dangerous to operate a motor vehicle or machinery.

The fourth area of research found that rehabilitated opium and heroin addicts are increasingly using alcohol to replace narcotics as a way of coping with emotional strain. In this survey of ex-addicts, 69.8% of males and 69.5% of females indicated they considered alcohol to be a legal substitute for narcotics.

The researchers conclude that while alcohol consumption appears to be increasing, and though "alcoholism has been found to lead to serious social consequences in individual cases, its social costs are obviously much below the levels of other industrial countries."

The report also concludes "a significant proportion of industrial and construction workers consume alcohol, some to the point where efficiency and safety are threatened."

A final conclusion was that the general public, including management, and medical and social work personnel in Hong Kong, are poorly informed about alcohol-related problems and solutions, and that there was a need to "consider the planning and future direction of education and prevention programs."

Hong Kong: drinking beer and brandy in the bars of Wanchai and the oppulent Landmark Building (top)

INTERNATIONAL

Israel launches action plan against feared drug outbreak

By Michael Kesse

TEL AVIV — A National Drug Authority to coordinate all phases of the war against drugs in Israel has been proposed by Professor K. J. Mann, chairman of the Interministerial and Interinstitutional Committee on the Problems of Drug Abuse in Israel.

Dr Mann, associated for decades with the Hadassah Medical Organization in Jerusalem, was speaking at the 2nd International Congress on Drugs and Alcohol, held here.

The new authority would determine national policies on drugs, secure financial and manpower resources for dealing with drug problems, set priorities and coordinate activities of all bodies in the field, and propose legislative and law enforcement measures. It would not replace existing bodies, but would act as an umbrella organization.

Dr Mann stressed the drug problem was not acute in Israel at present, although the danger exists that at any minute an epidemic could break out. He said this could be avoided by proper preventive steps, if taken in time.

The few meagre studies among high school students since 1971 indicate that 3% to 5% use one or another of the softer drugs during their four years in high school.

But the incidence soars to 47% among high school drop-outs who join (or form) street gangs. The number of street gang members was estimated at between 10,000 and 20,000, but there are no exact figures.

The latest general population study, made by the prestigious Institute of Applied Research in 1982, shows that 3% of the adult population has used hashish at least once, and 2% use it frequently.

The total number of "true" addicts (people who cannot function without drugs, hard or soft) in Israel is not known, but is variously estimated at between 3,000 and 5,000 from a population of about four million.

The latest (1982) Police Annual lists 2,203 instances of arrests for the use of dangerous drugs; another 1,493 people were picked up for pushing drugs.

However, minimal figures notwithstanding, Dr Mann said Israel is a fruitful area for a "violent outbreak" in the use of both soft and hard drugs.

Its geographical position — Israel is in the middle of the crossroads of the Hashish Connection — is one reason, and cannabis is also grown widely in nearby Lebanon. Small coastal boats carry it to Egypt, or it goes overland to Syria and then into Jordan, reaching the West Bank and Israel as a result of the "open bridges" policy over the Jordan river.

Secondly, many immigrants to Israel have not become fully acclimatized to Western culture, and may have come from lower social strata in countries where hashish use is commonplace.

The potential explosiveness of the situation led the government four years ago to set up the 25-member committee which Dr Mann heads.

After years of work, the committee declared there is little solid epidemiological data (except for those mentioned above); moreover, "there was a complete absence of a critical evaluation of preventative and curative measures."

To address this, the Committee is demanding a Research Committee to gather national data (including the military forces), to evaluate preventive and curative measures already being taken, to study the interrelationship between individuals and society, and what weakens or reinforces this relationship; and finally, to study biological relationships between drugs and tissue, and drugs and personality.

The committee also feels major steps should be taken in prevention to be achieved by educating susceptible individuals at home, in school, at work, and especially within influential social frameworks.

The third main area to be strengthened is treatment, the best form being prevention — building a "personality" able to withstand temptation. Nevertheless, much thought must be given to preventing access to drugs, helping in withdrawal programs, and in keeping victims from relapse by using drug substitutes, says the Committee.

Development of treatment facilities should be in several stages:

- Mental health centres are needed in Jerusalem, Tel Aviv, Haifa, Acre, Ashdod-Ashkelon, Ramla-Lod, and Beersheba.
- Youth guidance centres must be set up in Jerusalem, Tel Aviv, and Haifa.
- Special outpatient clinics for the treatment and rehabilitation of addicts should be established in Ashdod-Ashkelon, Ramla-Lod, and Beersheba (they already exist in Jerusalem, Tel Aviv, Haifa, and Acre).
- A drug-free therapeutic "community" should be founded in one of Israel's principal towns.

After these units have been set up and are functioning, others should be added until there are 13 mental health centres, 11 guidance clinics, 13 special treatment and rehabilitation outpatient clinics, and the one drug-free therapeutic community.

Israeli children: building a personality to withstand temptation

'Prevention better than cure'

UK docs form anti-alcohol group

By Alan Massam

LONDON — The British medical profession has turned its full attention to the rising incidence of alcohol abuse and decided to act on the basis that prevention is better than cure.

It has set up through the Conference of Medical Royal Colleges and their faculties, Action on Alcohol Abuse, a pressure group which will tackle the problem in much the same way as the Action on Smoking and Health (ASH), established by the Royal College of Physicians some years ago, set about reducing smoking.

Daube

Chairman of the new organization is John Strong and secretary is Mike Daube, a former director of ASH.

Professor Strong said Triple A, as the new group will be known, will not attack the reasonable use of alcohol, only abuse and the social and medical ills that stem from it.

The first objective of Triple A is to seek ways to prevent moderate drinkers from becoming immoderate drinkers.

The launching of Triple A just preceded publication of *Drinking Behaviour and Attitudes in Great Britain** by the government's statistical service, the Office of Population Censuses and Surveys. Based on a survey by National Opinion Polls Market Research Ltd for the department of health and social security, it involved interviews with 3,493 adults.

The study found that more than two-thirds of male drinkers usually drank beer, lager, or cider, and most of the remainder (about one in seven) usually drank spirits. By contrast, no type of drink predominated among women drinkers; just over one-quarter usually drank spirits and fortified wines while table wines and beers were each the usual drink for between one-fifth and one-quarter of the sample.

On location of drinking, the study found that four-fifths of male and female drinkers said they drink at home, although moderate and heavy drinkers usually drink in a public house. Alcohol bought for consumption at home is usually obtained from a supermarket or food shop.

Awareness of the safe level of drinking (as defined by the Royal College of Psychiatrists at four pints of beer or its equivalent daily) varied according to different types of drink. More than half of the informants overestimated the safe level of beer, while only one in six did for spirits.

For each of the four types of drink included in the study, about one in 20 informants thought that any amount, however small, is sufficient to do harm. Moderate and heavy drinkers are most likely and abstainers least likely to overestimate safe levels.

Professor Strong said alcohol is implicated in 80% of deaths from fire, 65% of serious head injuries, and more than 50% of homicides. It is also well known to be involved in many traffic accidents.

One in five male admissions to hospital wards in Britain is related to the consumption of alcohol, and deaths from cirrhosis of the liver in Britain are up by 63% in the last decade.

Professor Strong estimated that £500 million (Cdn $906,600,000) is spent every year in Britain on treating preventable conditions associated with alcohol. And that estimate does not include the cost of psychiatric treatment which, again, heavily involves conditions associated with alcohol consumption.

It is estimated there are more than a million problem drinkers in Britain although the results of treatment can only be described as "indifferent."

*Office of Population Censuses and Surveys, St Catherines House, 10, Kingsway, London WC2B 6JP.

Low tar smokes reduce death rate

LONDON — An independent scientific committee has concluded the reduction in British cigarette tar yield in the past 20 years "appears to have contributed to the decline in death rates from lung cancer."

It has recommended a continued reduction in tar as well as a reduction in carbon monoxide yields.

On nicotine, however, the *Third Report of the Independent Committee on Smoking and Health** was less inclined to be restrictive. At the levels derived from smoking, nicotine had not been shown to harm the cardiovascular system, nor was there any evidence that it was carcinogenic or teratogenic, it said.

"While nicotine is probably the most important single reason why people continue to smoke, its exact role in perpetuating the habit is imperfectly understood," the report said.

"There is as yet insufficient evidence on the extent to which reductions in the nicotine levels lead to smokers trying to maintain their nicotine intake by 'compensatory smoking.'"

The report recommends that in the four years 1984 through 1987 reduction in sales-weighted tar delivery should continue at the same rate as set in the 1980 voluntary agreement between the government and the tobacco industry.

This would produce an average tar yield of about 13 mg per cigarette by the end of 1987. (The target was 15 mg per cigarette by the end of 1983.)

The committee adds that every new brand introduced onto the market should deliver less than 13 mg per cigarette.

Further, it says manufacturers should reduce carbon monoxide yields of cigarettes to "the lowest practicable values."

On publication of the report, junior health minister John Patten said the recommendations would be considered during the government's talks with the industry on a new voluntary agreement on product modification.

*Her Majesty's Stationery Office, Sovereign House, Botolph St, Norwich, Eng — £2.95 (Cdn $5.35).

Health body evens the score with No Smoking Cup game

LONDON — The Health Education Council (HEC) is getting into sports sponsorship as part of its campaign against smoking. It is sponsoring an athletics club and youth five-a-side football competitions with the slogan "Be a pace setter. Don't smoke."

A spokesman for the council said it was intended that the National Association of Youth Clubs Five-a-Side Football Competition would become the "No Smoking Cup."

Detox centre plan overrides opposition

Chalmers: almost willing to beg

MONCTON, NB — The New Brunswick Alcohol and Drug Dependency Commission (ADDC) will override opposition from residents of Moncton's northwest section and proceed with a $1-million, 18-bed detoxification centre, says ADDC Chairman Everett C. Chalmers, MD.

Controversy about the proposed site came in Dec 1983 in City Council. Deputy Mayor Dennis Cochrane, one of two ward councillors and himself a former neighborhood resident, asked Council to make sure citizens knew about a public meeting on the matter. Residents were then canvassed to sign a petition opposing construction. While many did, others refused.

The public meeting — attended by about 100 people — was held only a few hundred yards from the proposed site.

Moncton Mayor George Rideout said the provincial government owned the land and the ADDC was on a sound legal footing should it decide to proceed.

Mayor Rideout, a real estate developer and a representative of the Moncton and District Labor Council, and another Councillor who is a 16-year veteran of the Moncton Police Force, were against the plans.

The main fears were that property values would decline, that security would suffer, that patients would threaten public safety (especially that of children), and that crime would increase in the area.

Dr Chalmers appealed for support, saying he was "almost willing to beg for it." He said detoxification facilities are needed to help drug- and alcohol-dependent individuals face "stress, fear, anxiety," and the frustration of losing jobs, spouses, and financial well-being.

He debunked public perception of alcoholics as derelicts saying skid row drunks accounted for only 3% to 5% of the total. Dr Chalmers later argued that patients to be treated at the centre are harmless.

"You curl with them, play cards with them, and golf with them. But then, if you start talking about treating them in a facility, all hell breaks loose."

Announcing that the project would go ahead, Dr Chalmers said tenders have been called and work should be completed by fall.

New Brunswickers are paying more for their pleasures

Alcohol revenues are hitting record levels

FREDERICTON — Tax increases and price hikes helped push total New Brunswick Liquor Corporation (NBLC) revenues and profits to record levels in fiscal year 1982-83. But New Brunswickers are not drinking more — they're simply paying more for their pleasures.

The $58,173,276 profit on revenues of $173,237,683 (an increase of 12.1%) tends to obscure the fact that consumption changed only slightly over the previous year, when it actually dropped.

Higher federal and provincial taxes, higher import prices, revised markups, and other upward pressures on retail prices were mainly responsible for the almost 11% increase over the $156,085,499 of 1981-82.

Although New Brunswickers continued to favor beer three-to-two in dollar terms over hard liquor, consumption — which fell in 1981-82 by nearly 6% — increased only slightly.

Beer consumption was up only 1.1%, an increase to 74.84 litres per capita for fiscal 1982-83 from 74.60 litres per capita. Spirit sales declined for the second straight year to 5.81 litres per capita from 6.06 litres per capita, a 3.3% drop. Wine, on the other hand, showed a second consecutive gain, continuing a five-year pattern of increases. Sales were up 8.1%, a rise in per capita terms to 4.20 litres from 3.98 litres.

The sales breakdown in the NBLC annual report shows that beer accounted for 54.2%, spirits for 36.9%, and wine for 8.9%.

Based on the 1981 Canada Census population figure of 696,403 New Brunswickers spent $248.76 per capita on alcohol, but the increase over the previous year's $226.56 (calculated on a population of 689,000) is due almost totally to higher costs. Using that 689,000 figure (**The Journal**, April 1983), the per capita outlay would be an even higher $251.43.

The current fiscal year has seen several further federal and provincial tax increases, while the May provincial budget requires the NBLC to increase its revenues by $5 million.

Bob Bush, NB Beverage Room Owners' Association president, told NB Liquor Licensing Board chairman William Cockburn at the association's annual meeting that members are upset with the government's "ridiculous attitude" toward regulation, taxation, marketing, and advertising of liquor in the province. He said they want "consideration and cooperation" from those who make the rules.

Mr Bush said the government is going too often to the well with tax and price increases; as a result, customer demand is falling as prices soar.

Examples of price disparities cited were: a case of 24 beer costs about $18.40 in New Brunswick, compared to about $15 in Quebec, and $12 in Maine. A 40-ounce bottle of Canadian Club rye whisky costs $24.10 in New Brunswick, but only about $20 in Quebec, and $14 in Maine.

The complaints echo those made during the year by others in the industry. A common theme is that the vital tourist industry — by some standards the second-largest earner for the province — will be practically destroyed, especially when the high costs of gasoline, entertainment, and accommodations are added to those of alcohol.

Another irritant is that New Brunswick continues to prohibit media advertising of alcohol (in common with Prince Edward Island), while beer, wine, and liquor messages enter the province in out-of-province newspapers and magazines, cable TV, and radio programs.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. For further information, contact Margaret Sheppard at (416) 595-6150.

Doctor, You've Been Lied To

Number: 588.
Subject heading: Alcohol, alcoholism overview.
Details: 60 min, 16mm, color.
Synopsis: Alcoholics present more problems to their doctors than other patients, yet they do not reveal that their bruises, cuts, and depression are the result of their drinking. Patients who abuse alcohol often lie to their doctors. It is necessary for doctors to see through these lies if they are to be of help. Movie star Patrick O'Neal points out to a group of doctors many of the lies and denials that alcoholics use. He urges the doctors to become more aware, and to be ready to show sympathy and understanding, while always remaining firm.
General Evaluation: Good (4.2). This well-produced film had an important message.
Recommended use: With a resource person, could benefit health professionals, especially doctors.

Alcohol Awareness

Number: 589.
Subject heading: Alcohol, alcoholism overview.
Details: Four - 16 min filmstrips/tapes.
Synopsis: These four filmstrips cover a range of topics: the history of alcohol, what it is and how it is produced; how alcohol affects the body through progressive stages of anesthetization; why some people drink and others do not, and what young people should know to make this decision for themselves; how alcohol can be used appropriately, and the consequences of misuse.
General evaluation: Fair (3.3). These filmstrips were considered useful in providing an overview of alcohol and its use.
Recommended use: With a resource person, could be used with eight to 15 year olds.

The Late Great Me: Story of a Teenage Alcoholic

Number: 591.
Subject heading: Alcohol and alcoholism, alcohol and youth.
Details: 90 min, 16 mm, video, color.
Synopsis: Cherry is a shy 15-year-old girl who believes she is unattractive and "klutzy." Her mother pressures her to dress better and to go out with boys. The first day back at school, Cherry meets a boy, Dave, who is new to the school; he invites her to show him around the town. Dave brings a bottle with him that night and urges Cherry to join him by telling her it makes things much better. Cherry likes the feeling the alcohol produces and starts going out with Dave and drinking more and more. Cherry's progression shows increased problems at school and at home. Eventually she accepts help from her art teacher, a recovering alcoholic, and attends Alcoholics Anonymous.
General evaluation: Fair (3.3). While this film was well produced, and would make a good television movie, its length precluded its use as an education tool.
Recommended use: General audiences.

High Powder

Number: 590.
Subject heading: Attitudes and values, drugs and sports.
Details: 28 min, 16mm, color.
Synopsis: The captain of the high school ski team, Joe, is supplying drugs to team members. As a result of taking drugs, Rick has an accident skiing on an icy slope and is left paralyzed. Billy, Rick's best friend, must decide whether to inform narcotic agents about Joe. A further pressure on Billy is that his girl friend, Joe's sister, begs Billy not to tell on Joe. However, Billy decides that he must tell and as a result he is rejected by his team mates and girl friend. On the day of the big competition Billy confronts the team saying that he does not regret what he has done since he will not have to live with guilt if someone else gets hurt. Billy beats Joe in the race, and his girl friend realizes she was wrong.
General evaluation: Good to very good (4.8). This well-produced, contemporary film could lead to good discussion regarding the use of drugs and sports. General broadcast was recommended.
Recommended use: With a resource person, would benefit audiences aged 12 to 18 years.

Marijuana: Answers for Young People and Parents

Copies of the booklet, Marijuana: Answers for Young People and Parents (**The Journal**, Jan) are available **free to residents of Ontario.** Outside Ontario copies are 75¢ each prepaid from: Marketing Services, Dept 896, Addiction Research Foundation, 33 Russell St, Toronto, Canada M5S 2S1.

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NEWS AND DEPARTMENT

Soft signs aid detection of compulsive gamblers

LAWRENCEVILLE, NJ — Recognition of the "soft" signs of the compulsive gambler, such as high energy levels and use of the telephone to the extent that it disrupts social activities, may help to identify the condition earlier, Robert L. Custer, MD, said here.

Dr Custer told the 1st Statewide Conference of the Council on Compulsive Gambling of New Jersey that probably only 5% of compulsive gamblers are seeking treatment.

Dr Custer, chief of Treatment Services and Mental Health, Central Office, Veterans Administration in Washington, helped define compulsive gambling as a disease.

He explained that three "hard signs" are necessary for a definite diagnosis of compulsive gambling: a chronic and progressive inability to resist impulses to gamble; at least three of a list of seven disruptions of family, personal, or professional pursuits; and exclusion of an anti-social personality disorder.

He emphasized the gambling must be progressive: "I have known gamblers who gambled $20 a day every day of their life — that does not fit into any progressive pattern."

While Dr Custer said he hoped the strict criteria and tight diagnosis would avoid the problems of definition that have plagued the alcoholism field, such hard signs tended to be late signs. Soft signs, he said, might identify people who need help.

The soft signs of the compulsive gambler were determined, Dr Custer said, by comparing the incidence of various traits among diagnosed gamblers and controls. The compulsive gambler has a high energy level and a work performance consistent with workaholism, he said. Sleep disturbances are often found.

In general the compulsive gambler has no hobbies, tries to avoid conflict by lying, and is highly critical of the spouse's friends and family. The compulsive gambler likes people who take risks. He considers himself either very generous or very stingy — "rarely anything in between."

The telephone is used to the extent that it disrupts social and professional activities — "I've never seen a patient who doesn't ask to use the phone."

Compulsive gamblers rarely had savings accounts as children, Dr Custer said, noting that they learned money is to be used, not saved. Their borrowing pattern at legal institutions is progressive in amounts and frequency; life insurance policies are cashed in and discontinued; and compulsive gamblers have a very high tendency to pawn their own and their spouses' jewelry.

They usually had had a big win — often greater than six months' salary — in the beginning, and they had usually counted it out in front of their spouses to impress them.

New Books

by RON HALL

Substance Abuse Book Review Index 1982

. . . *by Jane Bemko*

This edition of the Index completes five years of reviews. Since 1978, it has indexed reviews of 721 books whose contents either wholly or partially deal with alcohol, other drug abuse, or with closely related fields. In 1978, 242 journals were scrutinized for reviews and the number has grown to 315 in 1982. The approach to the volume is first by author or editor. In this section, the full citation of the book has been given with a list of its reviews that have appeared during the year. There are indices by authors' and editors' names, by book titles, and by subjects. This edition contains a listing of 228 titles.

(Addiction Research Foundation, Marketing Services, Dept JR, 33 Russell St, Toronto, ON M5S 2S1. 1983. 57 p. $6.95. ISBN 0-88868-083-X)

Alcohol and Youth

. . . *edited by O. Jeanneret*

In 17 invited contributions, this volume summarizes work concerned with the influence of alcohol on infant, child, and adolescent health. The intention was to cover the whole period of risk, up to and including dependence on alcohol and notably the crucial period of 'learning to drink,' which can extend into the adolescent years and involve other learning situations such as driving a motor vehicle. For the content, an attempt has been made to be as thorough as possible, omitting no important lines of current research, at the same time avoiding very specialized work. For the format, three 'tiers' were chosen: biomedical, psycho-social, and legal and forensic. Contributors were sought for their competence as well as to enable an equilibrium between the three or four languages most used in the Occident and between the geographic regions of which it is composed. German, English, and French summaries are provided for the papers. The first section deals with biological mechanisms involved in alcohol intoxication and addiction, with a major emphasis on the fetal alcohol syndrome. The second part is devoted to the psychosociology of the child's inevitable encounter with alcohol. Specific topics include the development of attitudes toward alcohol and alcohol dependence, drinking patterns, and habits of children and adolescents in different cultures. The final section discusses legal and forensic issues, including possible regulation of alcohol advertising to youth, the association between delinquency and alcohol use, and legal strategies which might aid the protection of minors from alcohol-related problems.

(S. Karger AG, PO Box CH-4009, Basel, Switzerland. 1983. 208 p. $56.50. ISBN 3-8055-3655-0)

Other books

Young Driver Accidents: Magnitude and Characteristics of the Problem — Mayhew, D.R.; Warren, R.A.; Simpson, H.M.; and Haas, G.C. Traffic Injury Reseach Foundation of Canada, Ottawa, 1981. Need for a research program on young driver accidents in Canada; program design; sources of data; traffic injuries to young people as a health and safety problem; young driver over-representation in traffic accidents; alcohol as a factor in young driver crashes. References; appendices. 163 p. Traffic Injury Research Foundation of Canada, 171 Nepean St, 6th Fl, Ottawa, ON K2P 0B4. $7.50.

Behavior in Excess; An Examination of the Volitional Disorders — Mule, S. Joseph (ed). Free Press, New York, 1981. Substance abuse including narcotics, stimulants, sedatives, hypnotics, hallucinogens, alcohol, marijuana, tobacco, and caffeine; overeating; anorexia nervosa; overwork; compulsive television viewing; impact of environment on excessive behavior and habit formation. Index. 396 p. Free Press, 866 3rd Ave, NY, NY 10022. $25. ISBN 0-02-922220-6.

Consequences of Drinking — Giesbrecht, Norman; Cahannes, Monique; Moskalewicz, Jacek; Osterberg, Esa, and Room, Robin (eds). Addiction Research Foundation, Toronto, 1983. Trends in alcohol problem statistics in seven countries; description and analysis of post-war trends in mortality, morbidity, public disruption, crime, and traffic accidents related to drinking. 145p. Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1 $20. ISBN 0-88868-080-5.

Alcohol, Drug Abuse and Aggression — Gottheil, Edward; Druley, Keith A; Skoloda, Thomas E; and Waxman, Howard M. (eds). Charles C. Thomas, Springfield, 1983. Sociocultural perspectives; alcohol use and violence; heroin addiction; family violence; biological perspectives; pharmacotherapy for violent behavior; aggression-stress-alcoholism; psychological perspectives; summary and overview. Index. 360p. Charles C. Thomas, 2600 S 1st St, Springfield, IL 62717. $34.50. ISBN 0-398-04787-1.

The Alcoholism Problems: Selected Issues — Cohen, Sidney. Haworth Press, New York, 1983. Nature of alcohol; blood alcohol concentration; fetal alcohol syndrome; alcoholic hypoglycemia; alcohol and the liver; nature of alcoholism; hangovers; alcohol withdrawal syndromes; problem drinking in adolescents; treatment; alcohol/drug relationships. Index. 203p. Haworth Press, 28 E 22 St, New York, NY 10010 $19.95. ISBN 0-86656-209-5.

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Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Pharmacology and Drug Abuse Course — Feb 6-8, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, (ARF) 8 May St, Toronto, ON M4W 2Y1.

The Canadian Society of Hospital Pharmacists 15th Annual Professional Practice Conference and Drug Information Symposium — Feb 6-8, Toronto, Ontario. Information: Canadian Society of Hospital Pharmacists, 123 Edward St, Ste 303, Toronto, ON M5G 1E2

The Future of Psychiatry — Feb 8, Toronto, Ontario. Information: Dr Frank Cashman, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Incentives and Future Directives for Private Practice (or — What "They" Don't Tell You About Private Practice) — Feb 8, Toronto, Ontario. Information: Larry Waterman, PhD, 2306-857 James St, Woodstock, ON N4S 8H5.

Family Violence: Counselling Men Who Batter — Feb 8, Toronto, Ontario. Information: Dr Lyz Sayer, 98 Moore Ave, Toronto, ON M4T 1V3.

Cognitive-Behavioral Interventions: Clinical and Educational Applications — Feb 8, Toronto, Ontario. Information: Dr Paul O'Grady, 3018 Southmore Dr E, Ottawa, ON K1V 6Z4.

Update '84 for Family Physicians — Feb 9-10, Toronto, Ontario. Information: Continuing Medical Education, Faculty of Medicine, Room 114, FitzGerald Building, University of Toronto, ON M5S 1A8.

Drug Information Symposium — Feb 9-10, Toronto, Ontario. Information: Canadian Society of Hospital Pharmacists, Ste 303, 123 Edward St, Toronto, ON M5G 1E2.

Prevention Strategies Workshop — Feb 20-22, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Workshops 1983-84: Employee Assistance Program Management Update — Feb 22-24, Toronto, Ontario. Information: Yvonne Johns, department head, department of Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Relaxation and Stress Management Workshop — March 1-2, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Toughlove Weekend Workshop for Parents and Professionals — March 3-4, Vancouver, British Columbia. Information: Susan Wachtel, Community Service Foundation, PO Box 70, Sellersville, Pennsylvania 18960.

Detox Training Program (Nonmedical)— March 5-9, April 30-May 4, Toronto, Ontario. Information: Diane Hobbs, Coordinator of Detox and Rehabilitation Programs, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

Circuit and Rural Court Justice in the North — March 11-16, Yellowknife, Northwest Territories. Information: The Northern Conference, c/o Continuing Studies, Simon Fraser University, Burnaby, British Columbia V5A 1S6.

Instructional Methodologies Course — March 12-16, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

American Orthopsychiatric Association 61st Annual Meeting — April 7-11, Toronto, Ontario. Information: The American Orthopsychiatric Association, 19 W 44th St, Ste 1616, New York, New York 10036.

1984 Canadian Addictions Foundation Atlantic Regional Conference, Families and Drug Dependencies New Problems, New Challenges — April 29-May 3, Halifax, Nova Scotia. Information: Nova Scotia Commission on Drug Dependency, Ste 314, Lord Nelson Bldg, 5675 Spring Garden Rd, Halifax, NS, B3J 1H1.

North American Society of Adlerian Psychology and "NASAP 84" — May 25-29, Toronto, Ontario. Information: Katy Anderson, Publicity Director, Alfred Adler Institute of Ontario, 4 Finch Ave W, Ste 10, Willowdale, ON M2N 2G5.

25th Annual Institute on Addiction Studies — July 15-20, Hamilton, Ontario. Information: Karl N. Burden, Course Director, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

Summer Fundamental Concepts Course — July 16-19, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

1984 Annual Convention of the American Psychological Association — Aug 24-28, Toronto, Ontario. Information: American Psychological Association, 1200 17th St, NW, Washington, DC 20036.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-9, 1985, Calgary, Alberta. Information: Jan Skirrow, Chairman, 34th ICAA Congress, AADAC, 6th floor, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

United States

The New England Drinking and Driving Conference — Feb 13-14, Newport, Rhode Island. Information: New England Governors' Conference, 76 Summer St, Boston, Massachusetts 02110.

8th Annual Alcoholism Conference: Current Issues in the Treatment of Alcoholism — Feb 15-17, El Paso, Texas. Information: Vicki Hollander, Office of Continuing Medical Education, Texas Tech University Health Sciences Center, School of Medicine, Lubbock, TX 79430.

Examining Cocaine Issues and Effective Treatment Strategies — Feb 17, San Francisco, California. Information: National Addiction Research Foundation, 1850 Union St, Ste 296, San Francisco, CA 94123.

4th Annual Conference on Alcoholism and Chemical Dependency: Therapeutic Crossroads — Feb 19-22, Rancho Mirage, California. Information: Annenberg Center for Health Sciences, Eisenhower Medical Center, 39000 Bob Hope Drive, Rancho Mirage, CA 92270.

Pharmacology and Drug Dependence — Feb 27-28, Indianapolis, Indiana. Information: Kay F. Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

5th Annual Women in Crisis Conference: Women and Power — Feb 27-29, New York, New York. Information: Mari Nobles, 133 W 21st St, 11th fl, New York, NY 10011.

7th Annual Alcoholism Symposium, Diagnosis and Treatment: Current Developments — March 3, Cambridge, Massachusetts. Information: Douglas Jacobs, MD, Director, Continuing Education division, The Cambridge Hospital, department of psychiatry, 1493 Cambridge St, Cambridge, MA 02139.

The Alcoholic Family: A New Outlook — March 3, Boston, Massachusetts. Information: Mary Ann Kurtz, Human Resource Institute, 227 Babcock St, Brookline, MA 02146.

Cancer Survivor Revisted — March 8, New Hyde Park, New York. Information: Ann J. Boehme, Continuing Education Coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042.

3rd Annual Prevention Symposium — March 8-9, Anchorage, Alaska. Information: Claudia S. Brunner, Alaska Council on Prevention of Alcohol and Drug Abuse, Inc, 7521 Old Seward Hwy, Ste A, Anchorage, AK 99502.

Sexual Abuse in Chemically Dependent Families — March 9, Milwaukee, Wisconsin. Information: Candee Brandis, Training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

Alcoholism and the Aged — March 9, Buffalo, New York. Information: Research Institute on Alcoholism, 1021 Main St, Buffalo, NY 14203.

Toughlove Weekend Workshop for Parents and Professionals — March 10-11, Chicago, Illinois. Information: Susan Wachtel, Community Service Foundation, PO Box 70, Sellersville, Pennsylvania 18960.

Student Assistance Program — March 19-23, Milwaukee, Wisconsin. Information: Candee Brandis, Training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

International PRIDE Conference for Parents and Professionals — March 22-24, Atlanta, Georgia. Information: PRIDE, 100 Edgewood Ave, Ste 1216, Atlanta, GA 30303.

The Effect of Maternal Alcohol Use and Alcohol-Related Problems on Inter-Uterine Growth and Apgar Scores — March 23, Buffalo, New York. Information: Research Institute on Alcoholism, 1021 Main St, Buffalo, NY 14203.

Toughlove Weekend Workshop for Parents and Professionals — March 24-25, New Brunswick, New Jersey. Information: Susan Wachtel, Community Service Foundation, PO Box 70, Sellersville, Pennsylvania 18960.

Health and Addictions Seminar — March 25-30, Park City, Utah. Information: The Institute for Integral Development, PO Box 2172-T, Colorado Springs, Colorado 80901.

Sexuality and Alcohol/Drug Dependence — March 26-28, Indianapolis, Indiana. Information: Kay F. Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

Relapse Prevention Planning — March 29-30, Milwaukee, Wisconsin. Information: Candee Brandis, Training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

Economics of Alcohol Abuse — March 30, Buffalo, New York. Information: Research Institute on Alcoholism, 1021 Main St, Buffalo, NY 14203.

Joint Meeting of the Psychopharmacology Division of the American Psychological Association and the American Society for Pharmacology and Experimental Therapeutics — April 2-6, St Louis, Missouri. Information: Robert Balster, PhD, department of Pharmacology and Toxicology, Medical College of Virginia, Box 613, MCV Station, Richmond, Virginia 23298.

Reality Therapy Intensive Week 1 — April 9-13, Milwaukee, Wisconsin. Information: Candee Brandis, Training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

Ruth Fox Course for Physicians — April 12, Detroit, Michigan. Information: Claire Osman, Course Coordinator, American Medical Society on Alcoholism, 733 3rd Ave, New York, NY 10017.

National Alcoholism Forum of the National Council on Alcoholism — April 12-15, Detroit, Michigan. Information: Angela Masters, 733 3rd Ave, New York, NY 10017.

American Medical Society on Alcoholism — April 12-15, Detroit, Michigan. Information: American Medical Society on Alcoholism, 733 3rd Ave, New York, NY 10017.

5th Regional Conference on Substance Abuse "Innovations in Prevention and Treatment" — April 18-20, Cincinnati, Ohio. Information: Ann Blankenhorn, Central Community Health Board, 532 Maxwell Ave, Cincinnati, OH 45219.

National Conference on Women and Alcoholism — May 23-25, Seattle, Washington. Information: Dr Geri Marr Burdman, department of Community Health Care Systems, SM-24, University of Washington, Seattle, WA 98195.

46th Annual Scientific Meeting of the Committee on Problems of Drug Dependence — June 4-6, St Louis, Missouri. Information: Dr Joseph Cochin, department of Pharmacology, Boston University, School of Medicine, 80 Concord St, Boston, Massachusetts 02118.

2nd Congress of the International Society for Biomedical Research on Alcoholism — June 24-29, Santa Fe, New Mexico. Information: Richard A. Deitrich, department of Pharmacology, Alcohol Research Center, University of Colorado, Health Sciences Center, 4200 9th Ave, Denver, Colorado 80262.

National Association of Alcoholism and Drug Abuse Counsellors' Annual Conference — Aug 4-8, Indianapolis, Indiana. Information: NAADAC, 951 S George Mason Dr, Arlington, Virginia 22204.

The International Doctors in Alcoholics Anonymous Annual Meeting — Aug 9-12, Minneapolis, Minnesota. Information: Lewis Reed, MD, Information Secretary, IDAA, 1950 Volney Rd, Youngstown, Ohio 44511.

Alcohol and Drug Problems Association Northwestern Regional Conference — Oct 7-9, Seattle, Washington. Information: Eric Scharf, ADPA, 1101 15th St, NW, Ste 204, Washington, DC 20005.

2nd National Conference on Alcohol and Drug Abuse Programming for Colleges and Universities — Nov 11-14, Boston, Massachusetts. Information: Eric Scharf, ADPA, 1101 15th St, NW, Ste 204, Washington, DC 20005.

Abroad

An International Conference on Alcoholism and Drug Addiction — April 2-7, Canterbury, England. Information: Conference Secretary, Broadway Lodge, Oldmixon Rd, Weston-super-Mare, Avon, BS24 9NN, England.

6th International Conference on Alcohol-Related Problems — April 8-13, Liverpool, England. Information: Conference Secretary, MLCCA, 1st Floor, The Fruit Exchange, Victoria St, Liverpool L2 6QU, England.

International Institutes on the Prevention and Treatment of Alcoholism and Drug Dependence — Athens, Greece, May 27-June 2. Information: International Council on Alcohol and Addictions, Case postale 140, 1001 Lausanne, Switzerland.

15th World Congress of Rehabilitation International — June 4-8, Lisbon, Portugal. Information: National Secretariat for Rehabilitation, International Fair of Lisbon, Praca das Industrias, 1399 Lisbon-Codex.

III Congreso Iberoamericano sobre Alcoholismo — June 19-22, Cuenca, Ecuador. Information: Centro de Rehabilitacion de Alcoholicos, Casilla 331, Ecuador.

Families with Alcohol Problems: Models of Intervention — June 26-29, Dublin, Ireland. Information: Monica McGoldrick, Family Training Program, UMDNJ-RMS-CMHC, Piscataway, New Jersey 08854.

4th World Congress of Alternative Medicine — July 13-15, Amsterdam, Netherlands. Information: Dr Anton Jayasuriya, Secretary Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

3rd International Conference on Treatment of Addictive Behaviors — Aug 12-16, North Berwick (Edinburgh), Scotland. Information: William R. Miller, PhD, department of Psychology, University of New Mexico, Albuquerque, New Mexico 87131.

12th International Conference on Health Education — Sept 1-6, 1985, Dublin, Ireland. Information: Dr H.D. Crawley, Director, Health Education Bureau, 34 Upper Mount St, Dublin, Ireland.

International Congress on Alcohol Dependence, The Family and The Community — Sept 16-22, Jerusalem, Israel. Information: International Congress on Alcohol Dependence, the Family and the Community, Kenness International Inc, 1 Park Ave, New York, NY 10017.

11th International Conference of Social Gerontology — Oct 16-19, Rome, Italy. Information: International Center of Social Gerontology, 91, rue Jouffroy, 75017 Paris, France.

2nd Inter-American Symposium on Health Education — Nov 4-9, Acapulco, Mexico. Information: Symposium Steering Committee, c/o NARO, PO Box 2305, Station "D," Ottawa, Ontario, K1P 5K0.

Addiction as a disease?

The collision of prevention and treatment

By HarveyMcConnell

Debate about whether drug addicts should be considered as having a disease — a concept now generally applied to alcoholics by the treatment field — has collided with prevention efforts in the United States to reduce drug use and abuse in society, especially among young people.

A vociferous minority of lay people in the prevention field claims that application of the concept to all addictions is the first step toward legalizing drugs which are now illegal, and gives a message that most people can use drugs without problems.

This same minority — politically active and apparently growing in power, in the view of some highly-placed sources — considers some experts in the substance abuse field have contributed, by positions or actions taken in the past, to increased drug use by young people over the decade. It is attempting to prevent some of these experts from speaking at conferences, or remaining as advisers or members of various boards or bodies.

A target is David Smith, MD, founder and director of the Haight-Ashbury Free Medical Clinic in San Francisco, associate professor of toxicology at the University of California, San Francisco, and present or past member on advisory committees for organizations as diverse as the American Medical Association (AMA), the US Food and Drug Administration, and the National Organization for Reform of Marijuana Laws (NORML).

Because he fears what he sees as a rising current of anti-scientific argument and attempts at censorship, albeit by a minority, Dr Smith has decided to tackle publicly the situation and state his position.

In a discussion with contributing editor Harvey McConnell, he outlines his reasons for applying the disease concept to addictions, his view of the conflict between treatment and prevention fields, and his efforts to get others who agree with him privately to say so publicly. He also defuses claims that he has been a marijuana lobby activist.

"First of all, in my view, it has been established that alcoholism is a disease: a pathological state with characteristic signs and symptoms, and a predictable outcome.

It has been established that alcoholism is a consequence of genetic and environmental factors, and current research and treatment experiences indicate there is a commonality amongst all forms of addictive disease. Thus, addictive disease causation equals genetics plus environment.

If we apply this to cocaine, for example, about 30 out of every 100 people who experiment with cocaine will abuse at some time in their life in the sense they will develop some form of dysfunction as a result of the abuse. On the other hand, a lot of people will snort cocaine once or twice and forget about it.

Ten out of 100 people who use cocaine will abuse it to dysfunction characterized by compulsion, loss of control, and continued use in spite of adverse consequences.

Similar types of clinical studies, although much softer than those with alcohol — because most of the best methodological research has been done with alcohol —suggest this occurs with other drugs.

The best treatment for the individual who does develop an addictive disease is abstinence and recovery.

Although methadone maintenance is used for opiate addiction, many in the addiction field say this is not the best treatment. It is important to emphasize that it is possible for an individual who has addictive disease of the opiate type to get into abstinence and recovery. I believe this is the best treatment, although it is not the only treatment.

Among those who develop addictive disease there can be no return to controlled use, so treatments for all addictive diseases are similar.

The American Medical Association (AMA) has declared alcoholism a disease. To date, although we are raising the question with the AMA — and I am on the AMA committee on alcoholism and drug abuse — it has not declared addictive disease of other types a disease.

There is a growing push in this direction: the American Medical Society on Alcoholism is now expanding to include the full field of addictionology, the study and treatment of addictive disease, and there is growing emphasis on medical committees to combine study of alcohol and drugs.

This push operates under the assumption that if there is a commonality in the characteristics of the disease, to call alcoholism a disease, and the others not a disease, would be like saying that cancer of the liver is a disease, and cancer of the brain is a crime. In other words, this would fall under the weight of current research, clinical experience, and logic.

There is opposition to acceptance of the disease concept, and it comes from different sectors.

One area of opposition is among some corporations which will pay for treatment, but which will not say that alcoholism or addiction is a disease because they may have to pay more in personnel benefits. They are also afraid addiction may be declared an occupational hazard.

It is true, if it turns out all addiction is a disease, society is going to have to pay for treatment. My position is that paying for treatment is more cost-efficient than other approaches.

It is true, as well, that companies, if they declare addiction a disease, will have to pay more for treatment, which I happen to think is a good thing. I think this would substantially reduce the hidden costs associated with hidden, untreated disease.

The opposition by companies to the disease concept is financial. However, there is also a political, or political-legal opposition which is particularly rampant in the US among a certain small, but influential group, and it is happening behind the scenes all over the country.

What I hear is this: 'The disease concept says that only a certain percentage of individuals will abuse and develop addictive disease, and they will respond to the drug differently than others.

'Therefore, it means that a certain percentage can experiment with a drug without developing dysfunction and without developing addictive disease; therefore, you can jump in the water without getting wet; therefore, if you equate addiction to other drugs with addiction to alcohol, the next thing you will do is to want these drugs to be legalized.'

People are acting on this incredible leap in logic. These people operate a 'hit list' of a number of individuals in the field, including me, but I only want to relate what has happened to me.

These people make a leap in logic which has absolutely no substantiation in anything I have ever said or written. I have never said anything like that. In fact, I am the only person I know who now begins any lecture by saying I do not advocate drug use of any kind.

Smith: a leap in logic

There have been several attempts to have invitations for me to lecture withdrawn. All failed, until recently I was asked to be the keynote speaker at a major medical conference, then had the invitation withdrawn, and then was reinvited. The recovering community and the medical community, my main sources of support, got me reinvited.

After I spoke at a meeting in Colorado a little while ago, a woman came up to me and said that for the first time she understood why her son had cocaine addiction. She had been told by the censorship type of people not to come, and previously when she tried to find out why her son was addicted, she was told by the censorship-type people he was a bad person, society was bad, she was a bad parent, or there are people around advocating drugs.

Censorship on the disease concept prevents information from getting to families who need it. The woman in Colorado points to the failure to present to her accurate, state-of-the-art information about what we have learned about addictive diseases.

If there is a political climate in the US which makes you not advocate treatment for addicts, then you are furthering the cause for drug abuse because you're hurting addicted families.

I will say to these people that if they believe addicts should go to jail rather than treatment, then we have a real difference, and we have something to argue about.

But what I hear is: 'Of course, we don't believe that an individual who has an addiction should go to jail rather than treatment, but we can't say so publicly because it is politically unpopular.'

There is a legitimate conflict now between prevention and treatment. For example, some say that if you smoke a single marijuana cigarette once a week you will have long-term, irreversible damage. I think this is scientifically unsubstantiated.

'The best treatment for the individual who develops addictive disease is abstinence and recovery'

Take someone who has smoked 10 joints a day, drunk whisky, and used Quaaludes, has bottomed out and now wants to get into recovery. The first questions he would ask are: 'Is recovery possible, and am I irreversibly brain-damaged?'

In recovery the person has a lot of shame, guilt, and humiliation, wants to deal with this in recovery, and wants to believe that if he stays abstinent he will have full brain recovery at the end of a year.

A lot of research has shown that effects are reversible. The greatest case for irreversibility is for alcohol, but this is not included in the reasoning. You can make a case for some irreversible damage with certain drugs, particularly alcohol, but it turns out that with a year of abstinence, a lot of the changes are reversible.

Treatment does not say people should *not* be held responsible for their illegal actions or antisocial acts. If you kill somebody on the freeway and you are an alcoholic you deserve to be punished appropriately. The only thing we say is, consider the cause and look at the treatment alternative.

Recently, three baseball players addicted to cocaine were put in jail for conspiracy to buy cocaine. Now that should be a theoretical conflict: it would be like putting a public executive who is an alcoholic in jail for conspiracy to buy alcohol. The posture is that we must make a public spectacle of these people: it is like a public execution.

I object to that philosophically.

If cocaine addiction has caused dysfunction and illegal acts, I can see jail. You can have a mandatory referral to treatment with testing of biological fluid to make sure these addicts are in treatment.

You can come up with a series of scenarios where there is conflict.

Another thing I hear is that alcohol is legal and these other drugs are illegal. That, to me, doesn't make any sense because alcohol produces more violent crime than all other drugs put together, so to put the sole basis for the disposition of people on whether the drug they are compulsorily involved with is legal or illegal — that being the sole dividing line between jail or treatment or whatever — I object to, and that is a substantive issue.

What I say is, let's see if we agree or disagree in a political climate which makes a lot of people who even agree with me say 'yes, but I can't say that.'

Another thing which has been held against me has been my 10-year membership of the scientific advisory board of NORML (National Organization for Reform of Marijuana Laws).

I was never involved in policy making, and for years people have heard that my involvement has been minimal and peripheral. I have now resigned from NORML, not because of the political pressure, but because I want to focus on the specialty of addictionology, and because I don't want these people to gain political success by censorship and innuendo.

Now people will not have to say they disagree with David Smith because he belongs to NORML. They no longer have the luxury of evading that question by dealing with a peripheral issue: now they will have to deal substantively. Put up or shut up. Is addiction a disease or not?

I have never advocated the legalization of marijuana. Marijuana to a person who is addiction-prone is a dangerous drug.

We have a number of people in recovery who were living a chemical-free philosophy and they then used marijuana. It compromised their recovery and triggered their relapse back to their cocaine addiction.

For a group with an addictive disease, marijuana is a drug that has a high abuse potential. There are other people in our society who can use marijuana with no problem, like any other drug.

Addiction-prone people can't, and anything which increases the supply of drugs and the availability of drugs to addiction-prone people increases the potential that their addictive disease will be sustained or propagated.

I am concerned about the public advertising and endorsement of any psychoactive drug, including alcohol and cigarettes. I think there is far too much advertising of psychoactive drugs in our society as a way of getting people to use them.

As for the political pressure, it is from a minority, and I have been supported in many different areas. I get 10 lecture requests for every one I can take.

I can say this climate against the disease concept for drugs is among a minority, but it is increasing. It is happening."

'I have never advocated legalization of marijuana. Marijuana to a person who is addiction-prone is a dangerous drug'

THE BACK PAGE

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The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Canada resumes lobbying role

Tranquillizers now under international control

VIENNA — Diazepam and 32 other benzodiazepines have been brought under international control by the United Nations Commission on Narcotic Drugs.

At its eighth special session here in February, the Commission voted to include this group of tranquillizers in Schedule IV of the 1971 Convention on Psychotropic Substances.

At the international level, the strict minimum requirements of Schedule IV deal with licences, prescriptions for, and reports on quantities of drugs manufactured, exported, and imported.

The Canadian delegation, returning as a full member of the 40-nation Commission (**The Journal**, July 1983), played a central role lobbying for support of the recommendation.

Under the Convention, developing countries will be assisted in controlling these drugs, Jacques LeCavalier, director of the Bureau of Dangerous Drugs at Health and Welfare Canada, told **The Journal**.

This was a view shared by several other industrialized countries including France and Italy, two countries Canada had urged to reconsider their opposition to scheduling last year.

France and Italy, in fact, broke away from the European Economic Community and cast the crucial decisive votes on alprazolam, the first substance to be put to the vote. As a result, the number of affirmative votes reached 28, one over the 27 required for a two-thirds majority, setting the pattern for the remaining 32 votes.

The World Health Organization's (WHO) recommendation for control stated that the group of benzodiazepines, including diazepam (eg Valium, Vivol), chlordiazepoxide (Librium), lorazepam (Ativan) and nitrazepam (Mogadon) had the "capacity to produce a state of dependence and central nervous system depression resulting in disturbances in motor function, behavior, and mood." The WHO also stressed that the benzodiazepines were "being abused" to such an extent "as to constitute a public health and social problem" warranting international control.

Mr LeCavalier pointed out that developing countries may now use article 13 of the Convention to prohibit import of a large number of benzodiazepines — reducing the hazards associated with availability and simultaneously relieving the excessive burden of local control. Article 13 states: "A Party may notify all the other Parties through the (UN) Secretary-General that it prohibits the import into its country . . . one or more substances" and "if a Party has been notified of a prohibition . . . it shall take measures to ensure that none of the substances specified in the notification is exported to the country."

Scheduling the benzodiazepines under the Convention also means

(See — UN — Page 2)

Health chief vows to split tobacco, amateur sports

TORONTO — Health Minister Monique Begin's reputation as a negotiator is on the line as the controversy continues over the RJR-Macdonald tobacco company's sponsorship of the Canadian Ski Association's (CSA) national championships.

But she will not, for the moment, use legislation to force Macdonald to withdraw, said a ministry spokeswoman.

"She's back at the beginning and trying to persuade RJR-Macdonald and the CSA that the association between the two is unacceptable," said Laura Erola, special assistant to the minister.

"I guess this amounts to who has the most power and influence — who has the most persuasion."

A meeting between the two sides was expected as **The Journal** went to press.

Last year, RJR-Macdonald agreed to finance the CSA's 1984 national amateur championships, including ski-jump contests (see The Back Page), at a cost of about $1.7 million, spread over five years.

The decision immediately made the headlines when skiing superstar Steve Podborsky announced he wanted no link between himself and a tobacco manufacturer's product. (Late in February, he refused to accept the Export "A" Cup after successfully defending his Canadian downhill ski championship.)

Then, only two days before the first CSA event in Thunder Bay early in February, Ms Begin and the new Fitness and Amateur Sport Minister Jacques Olivier issued a joint statement condemning the Macdonald involvement.

But the decision to use the CSA championships to air no-smoking policies has disturbed a nest of political hornets.

The argument has caused a split within the CSA itself — one faction wants the Macdonald money while the other says no association with a tobacco company is acceptable, a view endorsed by Ms Begin and Mr Olivier.

Moreover, an informal coalition of people from a breadth of concerned health organizations is furthering the cause.

So far, the pro-Macdonald contingent — which includes some skiers, parents, organizers, and sports fans — has concentrated on the championships, leaving the politics to the politicians.

If and when it decides to take a stand, the effect could be considerable.

Meanwhile, Ms Begin will keep her sights fixed on the issue of tobacco companies vs amateur sport, and, at this juncture, has no intention of moving off it, says the spokeswoman.

But Macdonald and the CSA are

(See — Sponsorship — page 2)

Canadian skier Horst Bulau: in the shadow of tobacco money

Gasparik

Pharmacist attacks sloppy drug labelling

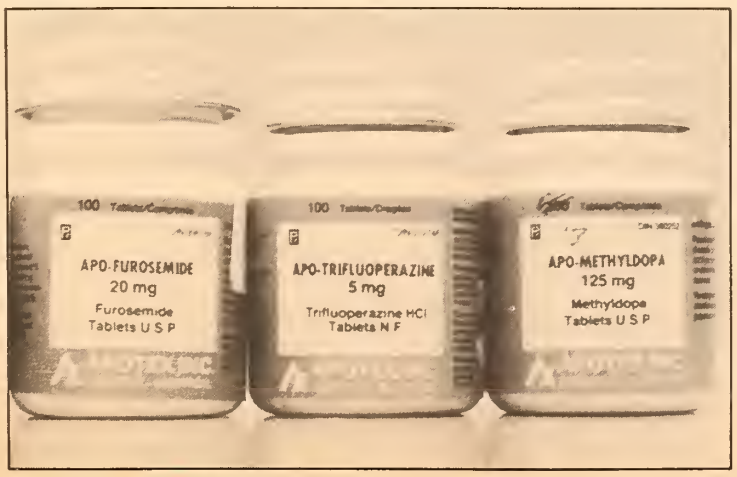
TORONTO — Drug companies have been strongly criticized at a pharmacists' convention here for paying too much attention to complicated package designs which can lead to "frightening" errors, and even death, in Canadian hospitals.

Reta Fowler told the 15th Annual Professional Practice Conference of the Canadian Society of Hospital Pharmacists (CSHP) that not one drug manufacturer currently markets a product meeting all CSHP packaging committee standards, although there have been improvements.

She said manufacturers must come up with clearer labelling to prevent the danger of potentially lethal overdoses. Otherwise, the profession could be forced to use group purchasing power as a lever to bring about badly-needed changes.

Mrs Fowler, director of pharmacy services for the Mississauga Hospital near Toronto and a member of the CSHP packaging committee, singled out three major areas where improvements are needed:

- "Not enough hospital pharmacists complain to manufacturers about poor labelling. They all complain to each other, but they don't send enough letters to the manufacturers.



Similar labels, different drugs: 'frightening' errors

- "Product managers in pharmaceutical industries change much too frequently to provide any continuity with respect to labelling and packaging, and that certainly is a problem.
- "And lastly, many manufacturers do not have a corporate policy regarding labelling, and they do not exert enough centralized control so that when labels *are* changed, they do not always change for the better."

But drug companies were not the only ones to come under fire. Mrs Fowler also criticized hospital pharmacists for failing to commend manufacturers for good labelling.

"I think this is even more rare," she said, "and I think we should make a point of doing that too."

Persuading manufacturers to adopt "classical" label and package design is a slow process, she

(See — Druggists — page 2)

INSIDE

NEWS

'Make trafficking unprofitable, uninteresting'

Global law on drug profits urged

By Anne MacLennan

VIENNA — Financial, legal, and enforcement experts from nine countries have called on the United Nations (UN) to formulate a world drug control treaty aimed at eliminating the fabulous profits in drug trafficking.

Canada's representative on the expert group, Superintendent Rodney T. Stamler, chief of the drug enforcement branch of the Royal Canadian Mounted Police, says the proposed treaty would make trafficking "unprofitable and uninteresting."

Unless the people of the world suddenly reject drug use, "there is only one way to really take the incentive out of drug trafficking, and that is to remove the profits," he told **The Journal**.

The treaty would be similar to the two chief international drug control instruments — the 1961 Single Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances.

However, it would concentrate on illicit proceeds of drug trafficking, enlarging and extending the provisions of those two treaties in the area of inter-country cooperation "in order to cover the gathering of evidence to ensure forfeiture of the profits and proceeds of drug crimes."

The recommendation for a treaty was one of several in a report to the eighth special session of the UN Commission on Narcotic Drugs in Vienna in February by the Expert Group on the Forfeiture of the Proceeds of Drug Crimes.

The report grew out of a series of expert meetings — the first was in October 1980 — on the increasingly sophisticated financial machinations of drug traffickers. (**The Journal**, Jan)

It outlines problems and identifies suggestions for action at both international and national levels.

At the national level, said Supt Stamler, "I think there's concensus that something has to be done in order to be able to seize the proceeds which are in your country when the individual (who committed the crime) lives in, and the original crime occurred in, another country.

"It's a secondary crime of possession. . . . If it's an offence to possess the proceeds, and the proceeds are in your jurisdiction, then you can go ahead with investigation. It gives each country the opportunity to establish laws so that it can take its own action within its own territory."

The report is to be circulated to member countries for study and will be given "high priority" for consideration by the Commission's secretariat in Vienna — the UN Division of Narcotic Drugs.

The expert group included members from Australia, Colombia, Egypt, the Federal Republic of Germany, Italy, Japan, Singapore, and the United States, as well as Canada.

UN vote will assist Third World

(from page 1)

participating countries are now obliged to treat people suffering from dependence on these drugs. The licit movement of benzodiazepines is now subject to import-export regulations under the Convention which is monitored by the Vienna-based International Narcotics Control Board (INCB). The Convention also requires licences for manufacture, trade, and distribution together with a report of these activities to INCB. And, the drugs can be dispensed only on prescription.

Professor Viz Navaratnam, director of the National Drug Research Centre at University of Science, Malaysia, told **The Journal** the decision to schedule the benzodiazepines "will have tremendous results as far as the developing world is concerned." As an example, he said countries could now insist on adequate information and demand that dependency-producing aspects of the drugs be emphasized in the accompanying literature.

Professor John Ebie of the University of Benin, Nigeria, who is also a member of the INCB, supported Dr Navaratnam's view and added the new controls would also go a long way toward preventing the supply of sub-strength benzodiazepines in Africa. This problem had plagued the medical profession in several African countries for a number of years, he added.

INCB member Professor Bror Rexed, a former chairman of the Commission, regards the vote as an important decision which will prevent the further polarization of views on drug control issues between the developed and the developing countries. He said the clearing up of the benzodiazepine issue would pave the way for closer collaboration at the international level.

He said as a result of difficulties the WHO had faced in reviewing the drugs for control because of the complexities of psychotropics and the conditions in the Convention, a new procedure for review has been adopted by the Executive Board of the WHO. It will allow for more in-depth analysis of the drugs for control.

Mr LeCavalier said he could foresee no immediate impact on Canada because these drugs are already subject to national controls equal to those envisaged under the Convention.

However, Canada is not yet a signatory to the Convention, and ratification would necessitate administrative and legal refinements in procedures, he said.

Druggists lobby for label changes

(from page 1)

said. Overly-artistic labels and logos cause serious difficulties in busy dispensaries. Designs which use stripes, for instance, or large company trade symbols, often make reading unnecessarily difficult and can lead to serious mistakes.

Ideally, the principal label should be devoted to product identification with the trade name, generic name, and strength displayed prominently . . . and "all of them have to be in a print size which is easily read."

Mrs Fowler said she doubted whether manufacturers would pay much attention to hospital pharmacists asking for label changes in over-the-counter products — "many users, however, are the pharmacists, the pharmacy technicians, and primarily the nurse who opens them, and they don't really care about the maker. They only care if they have the right drug in their hand; that is the thing which has to be emphasized."

But poor labelling does give rise to medication errors, said Mrs Fowler. Ampoules which seem to be about the same size can contain totally different drugs in totally different measures, and unless they are instantly identifiable, overdoses can occur and the wrong drugs be given.

Mrs Fowler said the CSHP had not yet taken an official position on the question of color-coding because of a fear that people may start selecting drugs by color, without bothering to read the printed information.

However, it can be useful, and specific instances should be supported by the CSHP, she said.

As an example, Mrs Fowler cited calcium chloride and calcium gluconate phials which look identical side-by-side in an operating room drug cart. They are similar preparations, but calcium chloride has three times the strength of calcium gluconate, and since the drugs can be used as part of emergency revival treatment in cardiac arrest, it is important that nurses and other staff can identify them easily and quickly.

Mrs Fowler said in the final analysis it is up to hospital pharmacists to bring about modifications.

"The power to influence labelling changes lies with the pharmacy purchasing groups in every province," Mrs Fowler stated. "The CSHP packaging committee can do a number of things, and we certainly tell manufacturers that we represent the profession. But in return, you have a responsibility.

"The bottom line is purchasing-power, and there's no question of it. No matter what we say in the packaging committee, it's you who do the purchasing who have final control. If you purchase products because they're cheaper, and the labelling is bad, it's your responsibility."

Mrs Fowler said pharmacists who agree with CSHP labelling guidelines should use them wherever possible. "Attach them to product complaints," she suggested, "attach them to calls for tender, and when tenders are rejected or accepted, it's important to let the manufacturer know why.

"With that kind of feedback, I think you will soon see a lot of labelling improvements."

Memorial fund will honor Ruth Segal

TORONTO — A memorial fund has been established in memory of Ruth L. Segal who died unexpectedly on February 3.

Dr Segal, a research scientist and head of the pharmacy department at the Addiction Research Foundation (ARF) here and assistant professor of clinical pharmacy, University of Toronto, had been science editor of **The Journal** since April 1977.

"Ruth's death has shaken both the Foundation and the Faculty of Pharmacy, for she was both colleague and friend to so many of us," Joan Marshman, PhD, president of the ARF commented.

"Her sense of caring and sharing, and her quick sense of humor made our lives warmer and brighter, and her many contributions to the Foundation's endeavors, including her clinical teaching of pharmacy students, were highly respected. She's left a permanent mark on us as individuals and on the Foundation as an organization," Dr Marshman said.

A member of the Association for Medical Education and Research in Substance Abuse (AMERSA), Dr Segal was part of the planning team for the November 1982 international meeting at Berkeley, California, co-sponsored by AMERSA, the United States National Institute on Drug Abuse, the US National Institute on Alcohol Abuse and Alcoholism, the World Health Organization (WHO), and the ARF.

She was also a member of the Health Professions Education Task Force which has evolved into the Association for Health Professions Education in Substance Abuse.

Dr Charles Buchwald, associate director of the Career Teachers Center, Downstate Medical Center, Albany, New York and secretary of AMERSA, commented that Dr Segal was "a prodigious worker and a spectacular person."

At the time of her death, Dr Segal was discussing development of a program for impaired pharmacists with the Ontario College of Pharmacists and the Ontario Pharmacists' Association. She also represented the ARF on the WHO advisory group working on a *Manual and Guidelines for Teaching on Drug and Alcohol Dependence in Medical and Health Institutions*. She was active on many committees of the ARF and the Faculty, had published widely, and had presented numerous papers relating to her specialty, alcohol and drug abuse.

Ruth Segal

Anne MacLennan, editor of **The Journal**, said: "As science editor, Ruth had become a trusted friend as well as valued colleague and supporter of **The Journal** over her seven years working with us. Professionally, but also personally, all of us who knew her are very saddened by and deeply regret her death."

Born in New Bedford, Massachusetts, Dr Segal earned her Bachelor of Science degree at the University of Connecticut and her Masters and PhD in pharmacy administration at Purdue University.

A memorial fund has been established to be used to further one of Dr Segal's particular interests. Contributions may be forwarded to the Dr Ruth Segal Memorial Fund, c/o Andre Charles, Addiction Research Foundation, 33 Russell St, Toronto, Canada M5S 2S1.

On behalf of the fund, Mr Charles will issue receipts and advise Ruth's husband, Dr Harold Segal, associate professor of pharmacy, U of T, and their two children of all contributors. Mr Charles will also advise contributors to what use the fund is eventually put.

Sponsorship debated

(from page 1)

just as firm in their mutual commitment. They have said they find their association beneficial and that they intend to continue it, unless the federal government somehow forces them to part company.

And if legislation is not being contemplated, there may be only one other weapon available to the government — save Ms Begin's powers of persuasion — the withdrawal of federal funding to the CSA, which amounts to $2.5 million annually.

Jeff Goodman, director of public affairs and public relations for RJR-Macdonald Inc, would like to see a clear resolution to the controversy.

"We don't want a confrontation — we're a private corporation selling a legal, legitimate product across the country which they (the federal government) legitimize by taxing it as much as they do. And they take the money from us to put out anti-smoking campaigns.

"I refer to this as the tyranny of the minority. The anti-smoking lobby is a small group, but they get a voice because the media pick up what they say because they raise controversy," Mr Goodman said.

John Read is a Calgary pediatrician, and father of Canadian skiing champion Ken Read. Dr Read has been associated with the CSA for many years, and is a determined supporter of the anti-smoking activists.

"It's a total anomaly that we spend millions of dollars on the treatment of smoking-related diseases. Our programs in schools are extensive, and they're costly. Then, to have a sport and fitness organization (the CSA) turn around and be able to promote the very thing we're trying to prevent doesn't make sense," he said.

NEWS

Correcting fluid deaths — a people problem

Label now warns against misuse

By Jon Newton

WASHINGTON — The addition of warning labels to all Gillette Liquid Paper containers has already begun in the United States and was to be implemented in Canada on March 1, a senior company spokesman told **The Journal**.

Two Canadian girls, one 14 and the other 12, died last year after sniffing Liquid Paper made by Gillette's Canadian division, Paper Mate (**The Journal**, Feb). The product, a commonly-used correcting fluid, contains 1,1,1,-trichloroethane (TCE), which also appears in a number of paint thinners and household cleaning agents.

TCE can cause fatal respiratory failure if inhaled in heavy concentrations.

Toxicologist Robert Giovacchini, PhD, Gillette US vice-president of corporate product integrity, said all Liquid Paper products will now carry hazard warnings. He said the solvent, TCE, could not be replaced in this product — "but all of this isn't really a product problem, it's a people problem."

He said he had been studying substance abuse since 1967 when he was part of a US Federal Trade Commission team set up to examine deaths involving a cocktail chiller using freon 12 in an aerosol spray can. "You'd get instant frosted glasses if you were trying to impress your friends," said Dr Giovacchini.

"The trouble was, youngsters were found dead in a house, or under a bridge, and the thing they all had in common was a balloon and a can of this cocktail chiller."

He said his company has been studying the problem of how to create labelling which effectively warns people against abusing a product. "We found out, for instance, that if you use the word 'intoxication,' it tended to give people the concept of getting drunk, as opposed to the substance being hazardous."

All Liquid Paper products will now carry the warning: "Intentional misuse by deliberately concentrating and inhaling the contents can be harmful or fatal. Non-flammable, non-hazardous when used as directed. Contains 1,1,1-trichloroethane."

UK mental health group warns of tranquillizer dangers

By Alan Massam

LONDON — Britain's National Association for Mental Health (NAMH) is concerned about the growing rate of dependence on minor tranquillizers (benzodiazepines) here and the fact that they are prescribed at great cost to the National Health Service (NHS).

It says in a new report, *Tranquillizers — Hard Facts and Hard Choices*,* that patients are not generally told:

- that minor tranquillizers can be addictive;
- that they have distressing and potentially dangerous side effects;
- that people who take them are five times as likely to have accidents as those who don't;
- that the drugs impair memory and intellectual functions;
- that they are only effective for a short time;
- that they are particularly hazardous to the elderly — the group most likely to get them on prescription;
- that withdrawal from benzodiazepines may have physical and psychological effects; and,
- that some research suggests an increased birth defect risk among babies of mothers taking the drugs during early pregnancy.

"There is now substantial evidence that these drugs are being prescribed for periods which exceed their usefulness," the report goes on. "Ideally, they should not be taken for more than four months in the case of anxiety and between three and 12 days for sleep disorders.

"Thousands of people have been on these drugs for up to 15 years and 1.5% of the population have been taking them for a year or more."

A NAMH spokesman told **The Journal** that benzodiazepine drugs are marketed vigorously to the medical profession and the result is an enormous and unjustified cost to the NHS.

"In 1981, £1.5 million ($2,655,000 Cdn) could have been saved on one product alone had its unbranded equivalent been prescribed. Five hundred 5mg tablets of Valium (diazepam) cost the NHS £6.81 ($12.05 Cdn) whereas the same number of an unbranded equivalent cost £1.25 (Cdn. $2.21).

Yet the more heavily-promoted Valium is prescribed twice as often as the cheaper alternative.

"The government's stated intention of increasing the efficiency of the health service rings hollow in the face of this poor housekeeping."

**Tranquillizers — Hard Facts and Hard Choices*, published by the National Association for Mental Health, 22, Harley Street, London W1N 2ED.

Cdn doctors could get 'life' for prescribing to addicts

OTTAWA — The Canadian Medical Association (CMA) supports Justice Minister Mark MacGuigan's plans to introduce legislation which could mean life sentences for doctors who knowingly prescribe narcotics or controlled drugs to abusers.

The move, which is part of proposed omnibus legislation to amend Canada's Criminal Code, would expand the definition of drug trafficking under the Narcotic Control Act and the Food and Drugs Act.

Doctors or dentists who prescribe drugs to patients knowing the substances will be used for non-medical purposes, could face life in prison.

CMA spokesman Douglas Geekie told **The Journal**: "We've been in contact with both Health and Welfare (Canada) and the Justice department relative to this and although we have yet to study the specifics, in general, we're in favor of the legislation."

He said the CMA wanted to ensure that physicians who were legitimately treating patients did not run afoul of the proposed ruling. But the association was behind any legislation that required doctors who were clearly trafficking to be prosecuted.

"We have indicated quite plainly that we have absolutely no objections to physicians found guilty of trafficking in narcotics or controlled drugs being treated exactly the same as anyone else," he added.

Doctors, however, are not the only ones to be affected by the amendments.

Anyone trying to obtain a narcotic, or a prescription for one, would also have to disclose details of every narcotic issued by a different physician within the preceeding 30 days. For failure to do so, penalties range from a maximum of seven years in jail, to fines of $1,000 and six months in jail for a first offence, or a $2,000 fine plus a one year sentence for a subsequent offence.

Coming up in

The Journal

- **US survey of student drug use**
- **A symposium of expert opinion on the issue of impaired physicians**

US approves Dilaudid-HP for relief of cancer pain

WASHINGTON — A modified form of Dilaudid (hydromorphone) has been approved by the United States Food and Drug Administration for pain relief in terminal cancer patients.

Marketing of "Dilaudid-HP" is seen by some as an attempt by the government to curb pressure from both within medicine and outside the profession to legalize heroin in the US for treatment of terminal cancer patients.

The earlier and weaker form of Dilaudid requires massive injections to achieve relief in patients who have developed a tolerance to it.

The more potent form, it is hoped, will help patients who lack the muscle mass to tolerate large injections of the weaker form of the drug.

A day in the life of a lottery czar

By Wayne Howell

The government lottery czar idly thumbs through his daily appointment book: 9 am — press conference featuring Mr Hard-working Citizen who has just won $13,000,000; 10 am — photo opportunity session to show off the new computerized lottery-ticket vending machines; 12 noon — working lunch with fellow lottery czars to coordinate draw nights and prevent overlap; 2 pm — appointment with Dirty Willy and Polecat Steve . . .?

A brisk executive finger punches a buzzer.

"Ms Wilkins. Is this some kind of joke?"

"You mean me not scheduling a three-hour lunch break?"

"No, no, not that. I mean who are these people scheduled for 2 pm — this Dirty Willy and this Polecat Steve?"

"I don't know for sure, Sir. They said they're part of a citizens' group and they want to make representations of some kind."

The government lottery czar sighs. Another Calvinist contingent come to berate him for involving the state in 'vice.' No problem. He'll give them the standard song and dance, trot out the usual facts and figures, and wow them with the latest Lottario promo showing a matron squealing, "It's such fun!" as she plunks down her money. A piece of cake. He heads off for his morning appointments.

Promptly at 2 pm, Dirty Willy and Polecat Steve arrive. Ms Wilkins is no more successful in getting Dirty Willy to remove his hat than she is at getting Polecat Steve to discard his much-used, much-abused toothpick. Dirty Willy gets right to the point:

"What you are doing is immoral and reprehensible and we demand that youse stop it."

"And who might I ask," says the lottery czar, "do you gentlemen represent?"

"We represent the PGAA — The Professional Gamblers Association of America," says Dirty Willy.

The state lottery czar cracks a smile and attempts a witticism. "In that case we are birds of a feather, are we not?" This does not have the desired effect. Polecat Steve spits out his toothpick in disgust.

"Youse guys have blackened the good name of gambling from Montreal to Monterey; so don't give us none of that birds of a feather crap."

"I don't understand," says the lottery czar, genuinely perplexed. Were not these rude men, in their own way his colleagues, no different in kind than the men he had just lunched with?

"Let me explain somethin," says Dirty Willy. "The Polecat and I are professionals. We make book. We quote odds. Skins over the Raiders by three-an'-a-half —take it or leave it. We set the odds so that half the bettors go one way, half the other."

"At least we tries to," says Polecat Steve. "We blew the spread on the Raiders sure enough."

"Don't interrupt," says Dirty Willy, "the point is, we try for an even balance. And we takes 10% from the winners and 10% from the losers — that's how we make our money." The lottery czar leans back in his Danish-modern chair and rolls his eyes in disbelief.

"I've never heard of anything so ridiculous in my life: half the people win and half the people lose and you only take 10% for your trouble? Good heavens, what do you call that?"

"We call it gambling," says Polecat Steve, inserting a fresh toothpick.

"You guys are putting me on. You're telling me you only keep 10%!"

"Well, sometimes 15%," says Polecat Steve, "but that's about as high as it gets."

"And the rest of the money goes back to the bettors?"

"Sure enough: try it if you don't believe us. We'll give you the Islanders over the Habs by two tonight: take your pick," says Dirty Willy.

"I told you it was fun!" squeals Polecat Steve, puffing up his cheeks and doing his best imitation of the obese counterman in Lottario's general store.

A worried frown appears on the lottery czar's face.

"Do many people know about this?"

"Not too many — we don't advertise on TV like youse guys do."

"Well, that's a relief . . . I mean I wouldn't want something like this getting around you know . . . like with us keeping the 90 and giving back 10 . . . well it wouldn't look so good would it?"

"It don't look good, and that is why Willy and I is here, because youse guys is debasing a fine and honorable profession and we want you to stop."

"But giving back most of the money to the people who make bets — that's incredible; there must be a law against it."

"There is," says Dirty Willy.

A brisk, executive finger punches a buzzer.

"Ms Wilkins. Show these criminals out. If they give you any trouble call security," says the lottery czar.

NEWS

RESEARCH UPDATE

Heroin-related kidney disease costly

Heroin-associated nephropathy (HAN) appears to be widespread in the United States and may have striking economic effects because of the high costs of maintaining kidney dialysis units, conclude three New York doctors. They surveyed 130 dialysis or nephrology units across the country. Twenty-three of the 32 respondents indicated they had cared for patients with suspected cases of HAN, for a total of 98 cases, the vast majority of whom were black males. HAN is seen among parenteral abusers of heroin and/or cocaine, usually between the ages of 18 and 45 years. Because HAN is unresponsive to therapy and usually progresses rapidly to renal failure, Eugene Cunningham, MD, Maria Zielezny, MD, and Rocco Venuto, MD, of the departments of medicine and preventive medicine, State University of New York at Buffalo School of Medicine, commented on the financial implications of the disease. They estimated the cost of treating 66 patients with HAN and end-stage renal disease at more than (US) $1.3 million a year.

Journal of the American Medical Association, Dec 2, 1983, v.250:2935-2936

Leaner body mass for smokers' infants

Low birth-weight in babies born to smoking mothers is primarily due to a reduction in lean body mass, concludes an Arizona study. It investigated 285 Caucasian mothers (109 smokers) who had healthy, full-term infants between 1976 and 1979. In addition to the mothers' smoking habits, the researchers examined composition of the newborns as reflected by anthropometric indices of subcutaneous fat deposition and lean body mass. The infants of smoking mothers were lighter, shorter, and had smaller head circumferences than those of non-smoking mothers. There was no difference, however, in subcutaneous fat, as measured by skinfold thickness in four sites. But, the calculated non-fat area of the upper arm was significantly reduced while the cross-sectional fat area of the arm was not.

American Journal of Clinical Nutrition, November 1983, v.38:757-762

Alcoholic liver patients only mildly dependent

People who develop chronic alcoholic liver disease are usually only mildly dependent on alcohol but have significantly more psychiatric disorders than patients with liver disease not related to alcohol, suggest separate studies from the liver unit of King's College Hospital, London. In one study, researchers investigated 126 men and 67 women admitted with alcoholic liver disease (usually alcoholic cirrhosis or alcoholic hepatitis) between 1979 and 1981. Sixty-three percent had no dependence or only mild dependence, while only 19.8% of the men and 13.4% of the women were severely dependent. Findings at a neighborhood alcohol treatment centre, however, showed 56% of patients were severely dependent. The researchers postulated that people who drink heavily become severely dependent and often seek treatment at an early stage. Others who drink at hepatotoxic levels but not enough to produce severe dependence "would not see the need to modify their drinking habits and some would continue to drink heavily over many years and ultimately develop cirrhosis." The second study of psychiatric morbidity compared 71 patients with alcoholic liver disease with a control group with non-alcoholic liver disease admitted to the same unit over 18 months. The researchers found 66% of patients with alcoholic liver disease had, or had had, psychiatric disorders, against 32% of the control group. Depression, neuroses, and anti-social personality were common, and 24% of the men and 54% of the women with alcoholic liver disease had an affective disorder which preceded their heavy drinking. The researchers concluded, "most patients with alcoholic liver disease do indeed have psychiatric disorders," which are often not recognized by medical staff and should be watched for.

British Medical Journal, Nov 12, 1983, v.287:1417-1422

Asthmatic addicted to aerosol treatment

Abuse of bronchodilator aerosols by a 17-year-old asthmatic woman has been reported by three British researchers. The woman was referred to London's Brompton Hospital because she used a cannister of beclomethasone and salbutamol weekly to "control" her asthma. She admitted using excess quantities for five years because of transient, pleasurable hallucinations produced by excessive inhalations. The researchers noted other cases of dependency and concluded the patient was probably dependent on the fluorinated hydrocarbons used as propellants, not the drug component. "If excessive use of aerosol treatment is noted, dependence should be suspected, especially when the asthma is mild," the study concludes. "Psychiatric intervention and the use of inhalation capsules may be helpful in preventing morbidity and mortality."

British Medical Journal, Nov 19, 1983, v.287:1515-1516

Heart rhythm problem often alcohol-induced

Money could be saved if young patients admitted to hospital with new-onset atrial fibrillation (AF) are tested for alcohol intoxication, a group of Denver doctors concludes. AF is a common disorder of heart rhythm that can be associated with several serious disorders. Usually patients admitted to intensive care undergo a battery of expensive tests. The study investigated 40 patients admitted to Denver General Hospital with new-onset AF and found alcohol intoxication caused or contributed to 14 (35%) of the cases, and 63% of those less than age 65 years. AF in patients with alcohol intoxication was benign and in eight of the nine patients with pure, alcohol-induced AF, heart rhythms returned to normal within 24 hours. Since the cost of the standard workup of AF is substantial, the medical study team said it would be more cost-efficient to consider alcohol intoxication early as a diagnosis when patients less than age 65 are initially observed with new AF.

Archives of Internal Medicine, October 1983, v.143:1882-1885

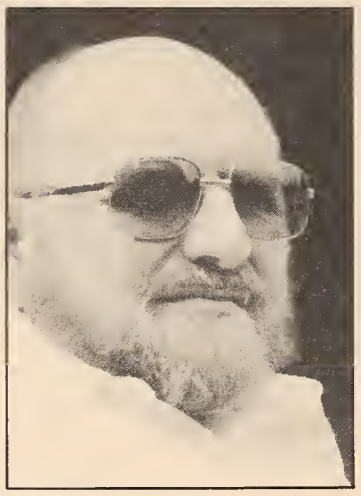
Pat Rich

US field must be coherent to be heard: Bestemann

By Harvey McConnell

WASHINGTON — Uniting the substance abuse field into a coherent force which will be listened to in Washington is a major aim of Karst Bestemann, new executive director of the Alcohol and Drug Problems Association of North America (ADPA).

Mr Bestemann, who succeeds Roger Williamson, has spent 26 years in the United States Public Health Service and retires as an assistant surgeon-general.



Bestemann: one voice

An experienced hand in the ways of Washington, he was for seven years deputy director of the National Institute on Drug Abuse (NIDA), which he left in 1980 to become a regional administrator for the Public Health Service (The **Journal**, Oct 1983).

Mr Bestemann told **The Journal** he considers one of the most important things he can attempt is to help the ADPA become a true unifying force in the field.

"I think this is important for the alcohol and drug field, because if we are going to do a good job of getting the kind of attention that we should have, we have to speak (more) with one voice and less with a lot of divergent voices not agreeing," he said.

"That's an old habit of the field we have got to give up. And I think the time is right. I am hearing this from other association chiefs and staff: 'Yes we want to get to work on this thing.'"

Equally important is Congress, and the ADPA had moved its offices into the shadow of the Capitol before Mr Bestemann assumed his post in February.

"I have always had good relations with staff, and House and Senate representatives on Capitol Hill," Mr Bestemann observed. "I think it is absolutely critical that they be educated to the issues, first just in terms of what the issues are . . . and then, after they really understand that, you can start to advocate."

Off-the-bat declarations that they should move in one direction or the other means legislators won't listen. "I think they deserve being given the best possible perception of the issues and then try and argue them into what you think is best for the field."

Mr Bestemann expects to appear before congressional committees later in the year when they consider reauthorization of the NIDA, the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the National Institute of Mental Health (NIMH).

"I would like to go up there (Capitol Hill) as one of six or eight or 10 national associations who agree about something so that the extent of the agreement and depths of the feelings are perceived. I don't think ADPA can go it alone — it is not the field," Mr Bestemann said.

(ADPA's new Washington address is Suite 181, 444 Capitol Street NW, Washington, DC 20001.)

14 deaths prompt action

US clamps down on look-alikes

WASHINGTON — Use of look-alike drugs is now so prevalent in the United States they have been categorized separately in the Drug Abuse Warning Network (DAWN).

At least 14 people in the US are known to have died after taking look-alike drugs, most from a caffeine overdose. Twelve were women, 10 of whom were younger than 30.

The US Food and Drug Administration recently told the 350 "look-alike" manufacturers and distributors that its new rules outlaw marketing of stimulants with any active ingredient other than caffeine. Laws have been passed by 43 states banning the distribution of look-alike drugs.

Look-alike "uppers" generally contain a combination of caffeine, phenylpropanolamine (PPA), or ephedrine, and "downers" contain antihistamines. Well-documented cases have linked look-alikes to severe hypertension with cerebral hemorrhage, insomnia, anxiety, and tachycardia.

Until this year, hospital emergency rooms across the country taking part in the voluntary DAWN data reporting system, run by the US National Institute on Drug Abuse (NIDA), have recorded look-alike episodes either as mentions for amphetamines, or if known to be look-alikes, as separate mentions for caffeine, PPA, or ephedrine.

Meanwhile, the final analysis of DAWN figures for 1982 shows 120,145 drug-abuse episodes were recorded in emergency rooms. There were 3,040 drug-abuse related deaths reported by medical examiners.

However, alcohol in combination with other drugs is the leading cause of most emergency room visits (29,348) and deaths (960).

The next most frequently mentioned drugs by those seeking help were diazepam (13,268), heroin/morphine (12,643), acetylsalicylic acid (aspirin) (6,868), cocaine (6,190), and marijuana (5,205).

The leading causes of death after alcohol in combination with other drugs were heroin/morphine (832) and codeine (349).

Suicide attempts were cited by more than 40% of those who visited the emergency rooms. Overall, 53.1% involved were females; 60% (of both men and women) were under the age of 30; and 12% were between six and 17 years of age.

Capitol Hill drug probe results in six charges

By Harvey McConnell

WASHINGTON — An 18-month investigation of drug taking on Capitol Hill here found substantial evidence that three former United States congressmen bought or used cocaine or marijuana.

But only six of more than 40 people investigated — an outsider and five low-level employees — were prosecuted following twin investigations by the department of justice and the ethics committee of the House of Representatives. Four were jailed and two were given probation.

In the end, no criminal charges or prosecutions were brought against the three former congressmen, or 42 House and Senate employees, including staff aides, employees of the House doorkeeper's office, and Capitol building tour-guides.

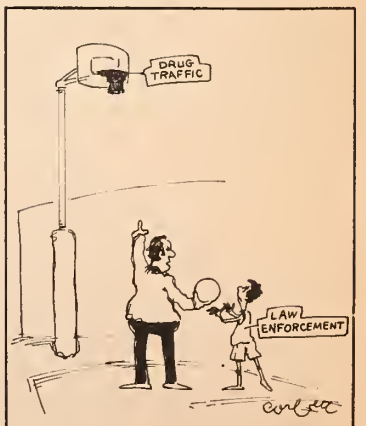
A report by the House ethics committee, which engaged Joseph Califano, a former secretary of Health and Human Services, to lead their investigations, concluded that columnist Jack Anderson, California republican representative Robert Dornan, and District of Columbia police detective Michael Hubbard, each in pursuit of his own objectives, together produced a series of charges and reports of illegal drug activities by some legislators and employees on the Hill.

Mr Anderson, whose column appears in the *Washington Post*, told the newspaper that the justice department did not pursue the case until he wrote about it because of the department's general policy of going after drug pushers and not users. He said he printed the allegations because they merited investigation.

Representative Dornan said he is shocked that many people do not consider involvement of 42 people in drugs as "a ring."

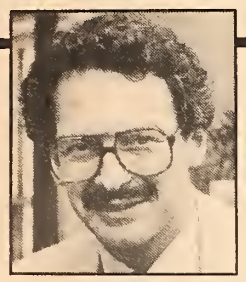
He added: "At least it was a good scaring and a good warning to the Hill."

Many officials concede that full scale investigations had to take place because legislators would otherwise be accused of a cover-up. At the same time, many also assume they have not uncovered all instances of drug selling on the Hill.



"Here kid, slam-dunk it."

COMMENT



GILBERT

'Now . . . the evidence points toward harm to healthy adults from second-hand smoke.'

Smoking and the workplace

By Richard Gilbert

One of the dramatic socio-pharmacological phenomena of the past three decades has been the near disappearance of smoking from the public eye. No firm data buttress this assertion, but the evidence for it is easy to come by. Look at 1950s movies. Read 1950s novels. They portray an easy acceptance of cigarette use in public places that is quite alien today.

My impression is that the decline in public smoking has been far greater than the decline in smoking itself, the extent of which has in many ways been exaggerated. It is certainly true that roughly one-quarter fewer adults smoke regularly today than 20 years ago. Given less attention is the fact that, until 1983, per capita tobacco use in Canada had remained more-or-less constant for two decades, and cigarette consumption had steadily increased, reaching a plateau around 1980 of about 2,700 cigarettes per year for each child, woman, and man. Only in 1983, preliminary figures suggest, did tobacco use and cigarette consumption decline by a substantial amount. The 5% fall during 1983 was to near 2,500 cigarettes per person per year, or roughly the level of 1973.

Second priority

Obviously all the extra smoking has been going on somewhere, and one place has been the workplace — for those of us fortunate enough to have jobs. The workplace, in my view, should be the second priority for efforts around smoking in North America during the next few years. The first priority should continue to be the prevention of smoking by children.

There are many reasons why employers might now restrict smoking in the workplace. Not the least is the evidence that profits can be elevated by imposing such restrictions.

United States estimates of the various costs to the employer incurred by each smoker as a consequence of smoking have ranged from $345 to $5,600. The increased profits result from increased productivity of both employees and plant, and from reduced fire insurance. Employees take fewer breaks and fewer sick days when workplace smoking is restricted. Much machinery works better when the air contains no tobacco smoke. Improper cigarette use continues to be the major cause of fires in all kinds of buildings.

Employers might also be motivated by altruistic concern for the health of their employees and be inclined to establish smoking cessation programs at the workplace as well as to restrict smoking.

Another factor may be fear of legal action in respect to hazardous workplace chemicals. Such action is much more likely to come from smoking employees or their relatives because smokers are more vulnerable to the effects of these chemicals than non-smokers.

I want to deal with just one of the many reasons for restricting smoking in the workplace: It is that an employee's health can be adversely affected by chronic exposure to other employees' tobacco smoke. Before elaborating on recent relevant evidence, let me digress a little on the fate of no-smoking legislation in Toronto.

Law

In the absence of provincial action or clear authority to do so, municipalities in Ontario have had, so to speak, to take the law into their own hands to regulate smoking in public places. The City of Ottawa paved the way in late 1976. Toronto followed in June 1977. In both municipalities the city solicitors refused to certify the public smoking by-laws on the grounds that there was no explicit provincial authority for their passage. (In Canada a municipality may legislate only on matters for which there is explicit permission contained within provincial statutes.)

Naturally the by-laws were challenged in the courts. The Toronto by-law was challenged on five counts by Helen Weir and Top Drug Mart Ltd in 1979. A panel of three judges in the Ontario divisional court upheld the appeal but in respect of just one of the five challenges — that concerning a feature of the by-law delegating some of the responsibility for enforcing the by-law to "the managers" of the public spaces regulated by the bylaw.

The most important part of their decision reads as follows

"Once the preamble [to the by-law] is accepted as factually correct, then it would seem that the municipality is empowered to pass a by-law such as this to regulate smoking. If the by-law does not meet with the approval of the majority of the voters of the municipality then undoubtedly the next ensuing election will ensure the presence of councillors who will see to its repeal."

Clearly the judges decided that the passage of such a by-law is not so much a legal as a political matter. What the judges were saying, in effect, was that a general provision in the Municipal Act concerning the "health, safety, morality, and welfare of the inhabitants of the municipality" gives authority for municipalities in Ontario to regulate smoking. Because the decision of the divisional court was not appealed, that decision is the law in Ontario.

In spite of what many regard as a clear-cut decision by the court, many municipalities have shied away from passing similar by-laws because of a claimed lack of proper authority. Consequently, there have been many requests to the Ontario government either to provide legislative, as opposed to judicial, authority for municipalities to act in this way or, better, according to many activists including the Toronto-based Non-Smokers' Rights Association, to enact legislation itself on the matter of public smoking throughout Ontario.

The premier of Ontario responded to one such request (from an Ottawa-Hull organization in 1981) as follows: ". . . *the proposal for an Ontario Clean Indoor Act unfortunately conflicts with the government's current policy concerning anti-smoking legislation. As stated in earlier correspondence on this subject, the government of Ontario does not intend to adopt provincial anti-smoking legislation at this time, but will continue to endorse the enactment of local by-laws to control smoking in specific areas.*"

Justification

As a member of the 1977 City Council, I was a strong supporter of the thrust to regulate smoking in public. However, I had some misgivings about the focus on the health effects of second-hand smoke. In my view, the evidence of harm to healthy adults was, at the time, insufficient to justify legislation on health grounds, although, because second-hand smoke was clearly irritating to other people, there was justification on the grounds of improving the welfare of Toronto's inhabitants. I was still expressing misgivings as late as a July 1983 column in **The Journal**.

In January this year I reviewed the evidence again. Now I feel that the balance of the evidence points toward harm to healthy adults from prolonged exposure to second-hand smoke. Here is a brief account of six of the studies I have become aware of since I wrote the July column that lead me to this conclusion:

1. In the March 1983 issue of the *American Journal of Epidemiology*, Kauffman *et al* reported a survey of 7,800 residents of seven French cities aged 40 years or more living with spouses and no other adults for at least 15 years. They found significant impairment of lung function among respondents of either sex who lived with smokers of more than 10 grams of tobacco a day, compared with spouses of non-smokers. Married women without paid work showed an even clearer effect. Impairment of lung function was related in a dose-effect manner to the amount of smoking by their husbands.

2. In the September 10 issue of *The Lancet* Correa *et al* reported a case-control study of 1,338 lung cancer patients in Louisiana. Non-smokers married to heavy smokers were found to have an increased risk of lung cancer, and so were subjects whose mothers smoked.

Carcinogens

3. In the May 1983 issue of *Cancer Letters*, Bos *et al* reported a Dutch study in which eight non-smokers were experimentally exposed to cigarette smoke by staying in a poorly ventilated room together with heavy smokers for six hours. Carcinogens were found in samples of air and in samples of the urine of the non-smokers.

4. In the May 5 issue of the *New England Journal of Medicine*, Foliart *et al* reported a study of the absorption of nicotine and carbon monoxide by six, non-smoking female flight attendants during a six-hour flight from San Francisco to Tokyo (**The Journal**, July 1983). They estimated that, because of passive exposure to cabin air contaminated with cigarette smoke, the attendants absorbed nicotine equivalent to one or more cigarettes. No significant absorption of carbon monoxide was detected.

5. In the September 17 issue of *The Lancet*, Trichopoulos *et al* reported an update of their controversial 1981 study of lung cancer among non-smoking women married to smoking men. The first report was criticized mostly on the grounds that there were too few subjects. Here, results from more subjects were reported, and the authors concluded that the additional data "increase the credibility of the hypothesis implicating passive smoking as a factor in lung cancer."

6. The results of a so-far-unpublished study conducted at McMaster University, Hamilton, Ontario, by Pengelly and colleagues, funded by federal and provincial governments and designed to detect the effect of the pollution from local steel mills on the health of Hamilton's children, were released in the fall (**The Journal**, Dec 1983). The researchers found that "the effects of second-hand smoke, particularly maternal smoking, were the ones most easily demonstrated. Particulate matter in the air did not appear to have a significant health effect."

The study in this area that has attracted the most attention and criticism is the 1981 report by Takeshi Hirayama who studied 265,118 people in Japan over a 16-year period (**The Journal**, April 1981). He found that non-smoking wives of heavy smokers ran twice as high a risk of contracting lung cancer as those married to non-smokers.

The tobacco industry mounted a massive campaign to counter the results, but it is generally agreed that Dr Hirayama has provided satisfactory responses to the technical criticisms of his work. Moreover, he reported at the 5th World Conference on Smoking and Health (**The Journal**, Nov 1983) that the wives of heavy smokers also had a three-fold increase in nasal cancer, a 60% increase in chronic bronchitis and emphysema, and a 30% increase in heart disease.

At the same conference, Dr Richard Peto of Oxford University stressed there is still no direct evidence of harm by second-hand smoke to healthy non-smokers. However, he added that "lung cancer is swiftly overtaking other cancers as the chief cause of death around the world" and that "many of the deaths are among non-smokers who are victims of others' smoke."

I am now inclined to agree that the balance of the evidence points to a harmful effect of second-hand smoke on healthy adults.

What has Toronto City Council been doing about second-hand smoke since 1979?

Most of the action has been on the matter of smoking in restaurants, a significant omission from the 1977 bylaw. In 1981 the Council actually resolved to legislate non-smoking areas in restaurants, but the intention was side-tracked by a small majority of Council and the voluntary route taken instead. The latest results of periodic surveys indicate that 14% of restaurants in Toronto provide no-smoking areas.

I spoke with the president of San Francisco's Board of Supervisors (equivalent to City Council) in January. Wendy Nelder advised me that San Francisco had chosen not to legislate no-smoking areas in restaurants because people have a choice as to where they eat. What the Board has done is pass extremely controversial legislation about smoking in the workplace because there people's choices are much more limited.

The San Francisco ordinance was passed in June 1983. It concerns offices only and does not cover property "owned or leased by state and federal government entities" and some minor exclusions. The ordinance, which was to have come into effect in July, has the following purposes:

- "to protect the public health and welfare by regulating smoking in the office workplace; and,
- to minimize the toxic effects of smoking in the workplace by requiring an employer to adopt a policy that will accommodate, insofar as possible, the preferences of non-smokers and smokers and, if a satisfactory accommodation cannot be reached, to prohibit smoking in the office workplace."

The maximum penalty is $500 for each day of non-conformity.

The ordinance did not come into effect in July because of a massive campaign launched by the tobacco industry to have it repealed by referendum. Enough signatures were collected to have the matter of repeal on the ballot for the November elections in San Francisco, but the move for repeal lost by 80,740 votes to 79,481. The law came into effect in December and becomes operational this month.

Dismay

The referendum result was greeted by the tobacco industry with dismay. An editorial in the *Tobacco Reporter* said: "*This vote marks the first time that the anti-smoking position has won in public referendum. Every other restrictive law on the books has been enacted by a governing body; not by public decree. Now the vote wasn't anywhere near a mandate; the margin was less than 1% (about 1,200 votes). So despite its defeat, the industry is still left with the solid evidence that half of San Francisco's voters are opposed to the idea. But half isn't enough . . . it is so critically important that the advocates of freedom are victorious.*"

Roger Mozingo, senior vice-president for state affairs for the US Tobacco Institute, which is at the forefront of fights against smoking restrictions in the US, was quoted as saying: "We have to ask ourselves why and how voters have been conditioned to the point that half of them could actually approve such insidious government intrusion in the private, individual workplace."

One answer to Mr Mozingo's question is that government intrusion may be the only way, in many cases, of ensuring that workers can be free from their colleagues' smoke.

NEWS

Half take medication improperly

Drug info leaflets will alert patients to risks

By Jon Newton

TORONTO — A major pharmacy chain in Canada has introduced Patient Advisory Leaflets (PALs) explaining in simple terms how and when to take medications, and warning about possible harmful side-effects.

PALs, giving information on 60 different prescription drugs, were introduced to all 184 Boots drug stores across Canada in January at an initial cost of $50,000. They were developed by Pharmasystems Inc of Markham, Ontario.

Boots director of pharmacy services, Wayne Marigold, told **The Journal** the information sheets are meant to help druggists provide easy-to-understand information to consumers.

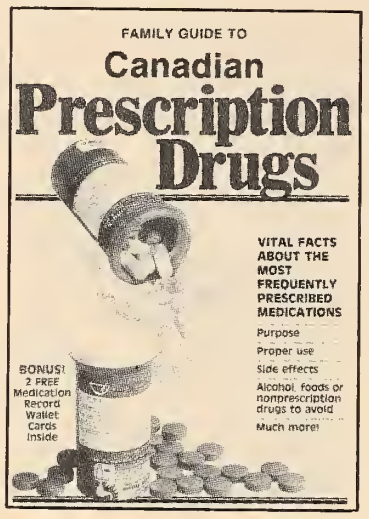
"People remember information best when they receive it both verbally and in writing," he said. "With the PALs, we believe our patients will better understand their medications and, therefore, receive the full benefit of their prescriptions."

Before formally introducing the PALs, Boots ran a pilot project in 30 randomly-chosen stores in Ontario, Manitoba, Saskatchewan, Alberta, and British Columbia. Each outlet was given consumer evaluation forms which were handed to customers who had received more than one PAL.

Of the several hundred respondents, 92% said PALs helped them to have a better understanding of their prescriptions.

Boots druggists say the PALs improve their ability to answer questions and advise customers, and the process is not too time-consuming.

Mr Marigold said the leaflets were designed to be understood easily by people with no more than a grade 6 education.



Paperback: a family guide

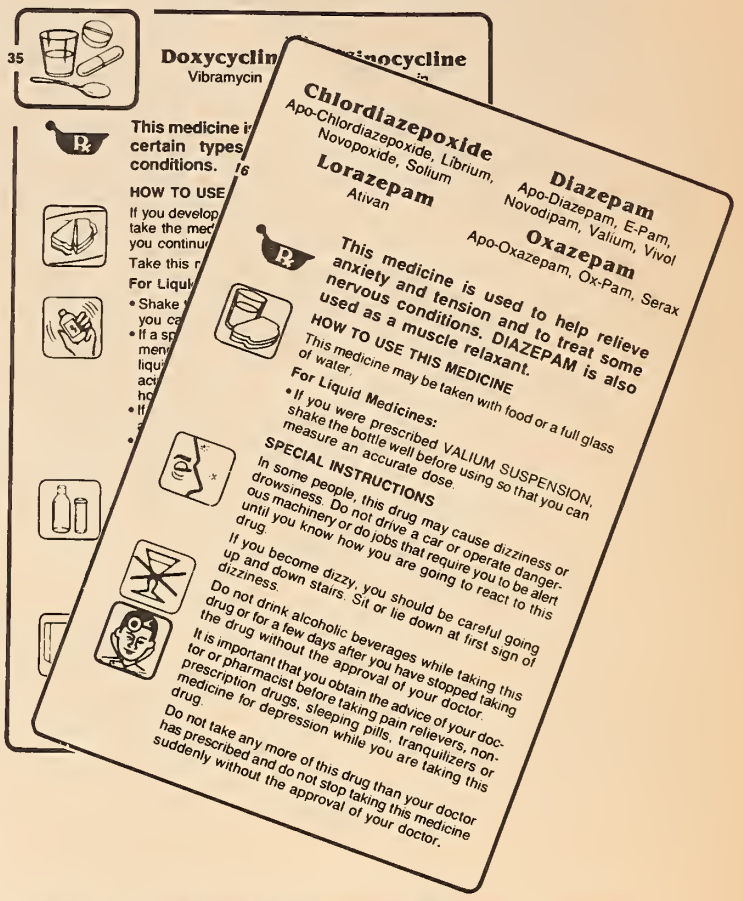
Drugs covered include, for example, nitroglycerine —"these medicines are used to relieve . . . angina attack. Carry the medicine with you at all times," and diazepam — "this medicine is used to help relieve anxiety and tension and to treat some nervous conditions. Diazepam is also used as a muscle relaxant."

Dorothy L. Smith, Pharm D, wrote the leaflets, which have now been compiled into paperback book form and will be available at about $4.95 each this spring.* In the preface she says one of every two patients fails to take prescription drugs properly.

Pharmacist Harry Sender, president of Pharmasystems, told **The Journal** he intends to publish regular up-dates of the book and leaflets as new medications are added to the series.

He said a second book, a family guide to non-prescription drugs, is underway. A third, for pharmacy students, nursing students, and other professionals, will also be produced.

**Family Guide to Canadian Prescription Drugs* — Smith, Dorothy L. Pharmasystems Inc, 361 Steelcase Rd W, Markham, ON L3R 3V8.



PALs: 92% of customers say the leaflets help them to understand

High-level drug users need tough monitoring

By Harvey McConnell

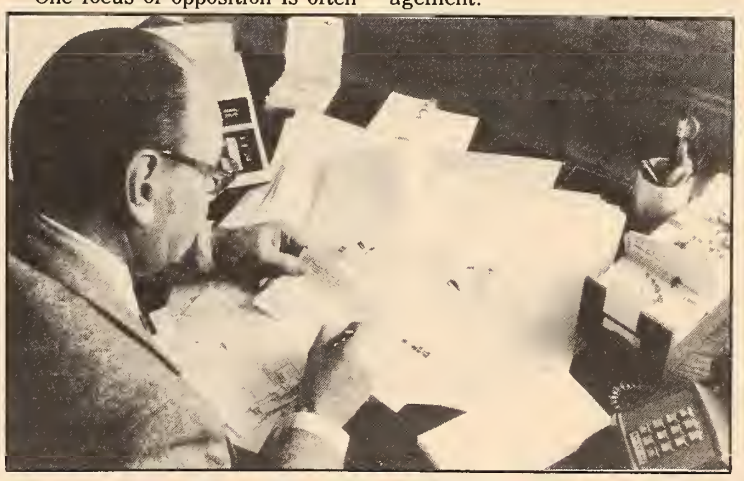
WASHINGTON — Personnel involved in substance abuse and who are in highly responsible positions must be monitored when they return to work, says a clinical psychologist.

And for such individuals — pilots, doctors, corporate leaders — improvement in their drug abuse patterns is not enough. "They must be drug-abstinent before returning to the workplace," said Donald Wesson, MD, assistant clinical professor of psychiatry at the University of California medical school, San Francisco.

Monitoring is vital to protect the public and the corporate image, he emphasized.

Once back at work, even a single episode of drug-related work impairment must be identified before the employee does harm. This means a monitoring mechanism to detect relapses in drug or alcohol use is necessary, Dr Wesson told a conference on substance abuse in the workplace here. The conference was organized by the American Society for Industrial Security and the Haight-Ashbury Free Medical Clinic San Francisco. (**The Journal**, Feb)

One focus of opposition is often trade union officials, who view with suspicion the singling out of individuals for drug monitoring, he said. Many believe such personnel policies subvert the union's role in protecting members from arbitrary or wrongful action by management.



Corporate leaders: forensic standards of checking are essential

Dr Wesson said that in therapeutic monitoring, in which the goal is detection of an early relapse, and where there are no disciplinary consequences of a drug-positive urine, normal screening methods alone are adequate. People confronted with positive urine tests will often acknowledge drug use.

However, in situations where a single, drug-positive test will result in disciplinary action, loss of employment, or loss of a professional licence, "forensic standards of sample collection, specimen handling, and analysis must be used. Each step in the process must be documented if the test results are to withstand legal challenge."

Dr Wesson pointed out that the transfer of urine, blood, or saliva from the subject to the container must be witnessed. If the individual is taken to a doctor for collection of a blood sample, the doctor becomes the first link in the chain of custody of the sample.

Dr Wesson said most doctors don't know the requirements of a legal chain of custody procedure, and they may handle blood samples by the usual clinical laboratory standards, which will not stand challenge by knowledgeable lawyers. Doctors must first be instructed in the legal necessity.

In addition, doctors could be residents or interns who will move to another geographic area within a year or so and will not be available later as witnesses. Thus, the blood sample collections should be witnessed by someone who can later give testimony.

Observers must verify accuracy of container labels, which should include the subject's name and other identifying information, date and time of collection, and type of collection receptacle. They must also maintain the chain of custody of the blood sample until it reaches the laboratory.

Dr Wesson continued: "Many drug users are skillful and creative in devising methods of deceiving an observer of urine samples. For example, males may tape a small tube to their penis and deliver a sample of urine from an attached balloon.

"They may also attempt to foil test results by adding an adulterant to the urine sample when they know drugs are present.

"The sophistication of some users is remarkable. Laboratory manuals listing reasons for false negatives have black-market value among some groups of drug users, and common means of spoiling detection of drugs in urine are published in the drug paraphernalia magazines."

Dr Wesson noted that in the "current litigious climate" in the United States and the "high sensitivity to the possibility of drug-induced impairment of an employee's function, a corporation employing a recovering drug user should assume an active, defensible position in situations of adversity involving the recovering employee."

For example, in medicine, a recovering anesthesiologist should give a urine specimen following any case with anesthetic complications to show that the adversity was not due to the anesthesiologist's intoxication. This would prove valuable in any malpractice suit.

Technology also exists to ensure that an airline pilot never assumes flight command while under the influence of alcohol. Every pilot could first blow into a breath-tester with the absence of alcohol vapor recorded on the plane's "black box" flight recorder.

Dr Wesson pointed out that mass urine screening in the US armed forces has demonstrably cut the number of drug-positive urine tests. (**The Journal**, Oct 1983)

"After frequent urinalysis is implemented and well known by the population to be tested, continued positive urine will occur only in drug abusers who have lost control of their drug use," he added.

Urine tests provide few false positives

WASHINGTON — Three immunoassay kits developed to detect cannabinoids in urine appear to be highly reliable in tracing marijuana smoking, says an ongoing study by the United States National Institute on Drug Abuse (NIDA).

A double-blind trial using volunteers at the NIDA addiction research centre, Baltimore, Maryland, was carried out on the EMIT-DAU and EMIT-ST kits, both produced by the Syva company, and the radio immunoassay (RIA) kit, made by Hoffman-La Roche.

Charles Gorodetzky, MD, PhD, scientific director of the NIDA's addiction research centre in Lexington, Kentucky, said for the past 13 years the agency has researched the development and evaluation of chemical methods for detecting drugs of abuse.

The trials were carried out on five healthy men aged 25 to 55 with a history of light-to-moderate marijuana use and cigarette smoking, and who were inpatients at the Baltimore facility.

All had had at least one week of negative urine for all drugs of abuse before starting the study.

Each subject was given — under double-blind conditions and in random order — one marijuana cigarette, two marijuana cigarettes, a placebo marijuana cigarette, or a standard tobacco cigarette. Each marijuana cigarette contained 10 mg of delta-9-tetrahydrocannabinol (THC).

Urine had to be cannabinoid-negative for at least three consecutive days before the next protocol, Dr Gorodetzky told an Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) science-press seminar.

In each assay an unknown sample is considered positive if the reading is greater than a cut-off standard for detecting the major urinary metabolite of delta-9-THC; 11 - nor-delta-9-THC-9 - carboxylic acid. The cut-off is 100ng/ml for both EMIT-ST and RIA, and a more sensitive 20ng/ml for EMIT-DAU.

Dr Gorodetzky said that in the 742 urine samples, the EMIT-ST and RIA were more than 50% positive for approximately 16 hours following one marijuana cigarette, and 24 to 32 hours following two marijuana cigarettes. The EMIT-DAU showed greater than 50% positive for 40 hours following one cigarette, and for 64 hours following two cigarettes.

Based on analysis of 282 urine samples for placebo cigarettes, tobacco cigarettes, and pretest conditions, there were no false positives by EMIT-ST and RIA, and 0.7% false positives by EMIT-DAU.

NEWS

Quebec supermarkets win beer, wine permits

By Terri Etherington

MONTREAL — Wine and beer sales at large, chain-owned grocery stores in Quebec will probably have little effect on alcohol consumption levels, says the head of one of the province's largest alcohol treatment centres.

Steinberg Inc won a protracted battle with the Quebec liquor permit board, which now allows the company to retail provincially-bottled wine and beer in 43 shopping centre outlets here. Liquor and imported wines and beers are sold only at government-controlled stores.

Of about 12,500 retail food outlets in the province, only 283 are chain-owned and therefore were not permitted to sell wine and beer prior to the January ruling. Steinberg now plans to apply for permits in the 58 remaining shopping centre locations. Other chain stores are expected to follow suit.

But Maurice Prévost, director-general of the Fondation Domrémy alcohol treatment centre, says while the decision worries him, he does not believe it will lead to an immediate increase in Quebec's alcohol consumption.

"We are concerned because we believe that accessibility is part of the global alcohol problem we have in North America," he said, but, "in our mind, personal susceptibility and factors linked to the immediate social surroundings, like family and workplace, play a much more influential role in the development of an alcohol problem."

The economy also has an effect, Mr Prévost said. People have had less money to spend on alcohol in the past two years. And, he added, "we see no reason for this change in the near future."

Eric Single, PhD, a research scientist in the epidemiology department of Ontario's Addiction Research Foundation, said the addition of new beer and wine outlets would probably not have as much impact as the initial increase in 1978, when Quebec went from a little more than 300 outlets to about 9,000 "overnight." (**The Journal**, April 1978)

However, Dr Single also noted that generally accepted theory holds that an increase in alcohol availability is related to increases in consumption which, in turn, are related to increases in alcohol problems.

He said an international study of alcohol control experiences showed that "the increase in availability clearly exacerbated the increase in consumption that was going on. It spurred it on, but it wasn't the sole cause." (**The Journal**, April 1982)

"The increase in the number of outlets might not have a major mechanistic kind of impact on consumption itself, but what it is going to create is more vested interest — store owners who are going to be against any kind of public health concern with alcohol pricing and taxation and who are going to be all in favor of further liberalization.

"Once you permit the sale of alcohol in grocery stores, you can't go back on it even if you find it becomes associated with large increases in consumption and alcohol problems.

"It would be very difficult to go back on it politically because now all these grocery store owners rapidly become quite dependent on alcohol and the profit they get from it."

Prior to the permit board's decision, only independently-owned grocery stores in Quebec were permitted to sell wine and beer. However, other large chain operations had developed primarily on the franchise system, meaning most of their stores were technically independent and thus permitted to sell domestic products.

The new ruling allows permits for corporate stores in shopping centres where it is believed they will not be in direct competition with smaller neighborhood outlets.

Normand St-Hilaire, press secretary to Quebec Justice Minister Marc-André Bédard, told **The Journal** applications will now be approved on a store-by-store basis. The main criteria for assessing applications is a market study showing what effect wine and beer in larger outlets will have on "corner stores" in the area.

"The real beer drinkers," Mr St-Hilaire said, "are the people who find themselves at the corner store.

"There is a lot of competition on the price of beer, so usually the beer drinkers know where the good prices are." Many corner stores use beer only to attract customers, making only a small profit on beer and taking their profit elsewhere, he said.

Mr Prévost told **The Journal** that liberalization measures, such as increasing the number of outlets, "should be taken with great care and only after impact studies."

Studies by Quebec's ministry of social affairs have centred on alcohol advertising, not sales, said Guy Versailles, aide to Social Affairs Minister Pierre-Marc Johnson.

Mr Versailles said his ministry, which deals with health and social services, was not involved in the decision to increase the number of outlets. In fact, he said, his ministry does not have any current campaign on alcohol abuse.

Women unlikely to buy 'caseloads'

Impact tied to marketing

MONTREAL — Wine and beer in shopping-mall supermarkets may mean an increase in sales only if the wine gets better and beer companies direct more promotion toward women.

Doug Long, communications manager for Steinberg Inc, says Quebec supermarket customers are 87% women, and they are unlikely to start "buying beer by the caseload" following the ruling. (See related story.)

Customers: 87% are women

"Beer is bought by a man traditionally. Maybe the beer industry here will follow the beer industry in the United States and wake up to the fact that there is another 50% out there who could become very interesting consumers.

"But we are far away from that here. Beer still has that big, macho image, and women don't seem to associate with it."

Mr Long said the wine that is sold in grocery stores is considered, by the average Quebecker, as "not even good table wine."

Grocery stores sell 77 labels of wine bottled in the province and approved for sale in other than the government-controlled outlets by the provincial liquor board. New labels of "grocery wine" will bring that total to more than 100 by the end of this year, he said.

But, unless the local wine industry improves the quality of wine and arrives at a price that is interesting to the consumer, there will probably be little impact on wine consumption, Mr Long added.

Cdn tobacco producers eye foreign markets as domestic sales drop

OTTAWA — Health and Welfare Canada is taking credit for a 4% drop in cigarette and cigarette tobacco sales over the past year, while the tobacco industry blames the decline on rising federal and provincial taxation.

Statistics Canada reported in January that monthly cigarette production had fallen about 9% between December 1982 and December 1983. Three days later, Health Minister Monique Begin attributed the sales slump to her department's smoking cessation program.

"This is the largest decline in annual cigarette sales in over 20 years," she said in a prepared statement, "and I hope it is the beginning of a clear reversal of the long-term trend that has seen cigarette sales increase."

But Jacques LaRivière, director of public affairs for the Canadian Tobacco Manufacturers' Council (CTMC), blames the fiscal environment for the drop in sales.

The Council represents Canada's four biggest cigarette manufacturers, accounting for 99% of total domestic sales.

"One has to look no further than the dramatic increase in taxation, both federally and provincially, over the last two years, for the primary cause of the decrease," he says. "With cigarettes as with any other consumer product, the higher the price, the higher the consumer resistance."

The CTMC has persuaded the Finance department to convene an inter-departmental task force to examine recent tax increases on tobacco and alcohol, but Health and Welfare officials say a 14% tax hike in 1982 simply brought cigarette prices back to their 1969 level.

However, the CTMC may have an unexpected ally in the task force, which will involve representatives from Health and Welfare and Agriculture Canada. Through price support programs, crop insurance, and research stations at Delhi, Ontario, and Joliette, Quebec, Agriculture Canada has been a consistent supporter of tobacco growers over the year.

"Agriculture Canada has been there front-and-centre in your industry's growth in research, inspection, and marketing," Agriculture Minister Eugene Whelan told the Flue-Cured Tobacco Producers of Quebec in a 1983 speech.

"The goal of our tobacco research program . . . is to develop better production techniques that will allow growers of flue-cured tobacco to improve quality, yield, and productivity," he said. "By doing so, we will be able to compete more aggressively and successfully in domestic and world markets."

It's this kind of talk that leads some Health and Welfare officials to point to the billions in badly-needed revenues that flow to provincial and federal coffers each year from tobacco taxes.

While the industry sees taxes as a disadvantage, the officials —who decline to be identified — say governments are developing a vested interest in ill health.

"Agriculture tries to help farmers while we try to get rid of tobacco. It's a head-to-head conflict," says one long-time observer. "The amount of money that goes back into doing something about the problem is almost invisible."

Agriculture Canada's input is also proving helpful to industry efforts to maintain the export position in the face of a world tobacco surplus.

"I would say the main concern from our standpoint would be to develop a stronger export market strategy so that we can either maintain or expand our exports of the product," says Nelson Longmuir, a senior market economist with the department.

"There's a world situation that's indicating the demand is going to decline over the next five to 10 years on the export market," he says. "You also have the domestic situation which is declining right now."

In both situations, Mr Longmuir explains, Agriculture Canada's position is that smoking "is not necessarily good for your health, but . . . people will smoke. They may as well smoke Canadian."

A development that has angered industry critics is the recent appointment of the leadership of Canagrex, the new Crown agency responsible for agricultural exports.

Ed Story, the organization's president and chief executive officer, is a former vice-president of RJR-Macdonald (See page 1 and The Back Page), one of the four major manufacturers of tobacco products. He and board member Ted Raytrowsky have an interest in promoting leaf tobacco exports.

In a report in the March 1980 *Tobacco Reporter*, Mr Raytrowsky said Southeast Asia represents "a gold mine" in which tobacco exports could double to 400,000 lbs in coming years.

"There are no non-smoking groups, and nobody from government is telling the Asians not to smoke," he said.

Mr Story told **The Journal** that Canagrex is responsible for encouraging the export of a number of agricultural products, of which tobacco is only one.

He said it will take some time for the agency to determine what prospects exist for different commodities and noted that he has only just begun the process of building trust with his former competitors in the tobacco industry.

Critics are somewhat less charitable.

"It's pretty easy to guess his mandate," says one observer. "He's going to be dumping tobacco on the Third World."

SIMCOE — Tobacco farmers near this small Ontario town are showing that when the anti-smoking battle gets too close to home, they're prepared to fight back. When local and county councils declared "Weedless Wednesday" and non-smoking weeks in January, the farmers retaliated saying they'd do their business in friendlier towns. Store owners and merchants, like this Simcoe car dealer, displayed "Smokers Welcome" signs showing which side of the battle they were on — tobacco farming is the kingpin of the area's economy.

Novak

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Please cancel our remaining subscription to **The Journal**.

Unfortunately, the informative articles we look forward to in your publication are overshadowed by writing contrary to our philosophy of the definition and treatment of alcoholism.

Specifically, the notion of fostering controlled drinking among alcohol abusers strikes us as a dangerous practice. The article, Early intervention key to BC controlled drinking success, (**The Journal**, Dec 1983) regarding a program in Vancouver is a prime example.

Certainly, we agree "situational" heavy drinking may result from stress, loss, or other external pressures. However, to attempt to teach controlled drinking, in our experience, is an "enabling" behavior of the highest order. Even thorough screening will not guarantee alcoholics are not admitted to such programs — in fact, most alcoholics we know would actively seek out such regimens. Abuse of alcohol by a non-alcoholic is, at least, a destructive coping mechanism. Correction should emphasize the development of new coping skills, not alteration of previously unsuccessful, high-risk behaviors.

Certainly, this story, and to an even greater degree Richard Gilbert's series (**The Journal**, Dec 1983, Jan), will win **The Journal** many supporters — especially in the alcoholic beverage industry. To think we have all been so concerned with the carnage on our highways when we should have recognized all along how many people were being *saved* through the benefits of alcohol use. Hasn't Dr Gilbert overlooked the most impressive figure of all? That, over the past 10 years, more than 250,000 people will *never* experience heart disease, cancer, or any health problems because they were killed in alcohol-related traffic deaths in the United States. Dr Gilbert, what about the other thousands of alcohol-related deaths that are never documented as such?

Perhaps such articles are printed in the interest of "neutrality." In our experience, non-commitment leads to inaction and poor results.

At any rate, there are other sources of current information which do not include material we find destructive and at cross-purposes to our philosophy and work.

John Hare
Director
Harold Hughes Hall
Alcohol/Drug Treatment Center
St Joseph Hospital
Ottumwa, Iowa

The Journal helps

WCTU is broadening outreach

I have appreciated receiving **The Journal** for many years. **The Journal** has helped me with my work on the Grey County School Board in Owen Sound, and in my work with the Ontario Woman's Christian Temperance Union (WCTU).

As Ontario President of the WCTU, I am greatly encouraged by the increased awareness and concern of the general public about alcohol addiction and related problems. The Ontario WCTU has recently broadened our outreach and involvement. I have attended committees recently where colleagues of the Addiction Research Foundation were participants.

Barbara Taylor
President
Ontario Woman's Christian Temperance Union
Aurora, Ont

Cannabis articles useful to military MD reader

The Journal is to be commended for its interesting and informative articles which are consistently of high quality. Reviews are particularly good, and the frequent cannabis reports help keep one current with the emerging medical consequences of using this drug.

I would appreciate receiving references for Dr Noble's article, Alcohol and the Brain (The Journal, March 1983), and look forward to reading more reviews like this one in future.

G.J. Cook, Major MD
Base Surgeon
Canadian Forces Base Chilliwack
Chilliwack, BC

TJ an asset to alcohol counsellor

I currently work as a counsellor for a private psychiatric consultant, in which I do a great deal of work with our alcohol abusing patients. I am very interested in your publication and would like you to place me on your mailing list or send me information on subscription.

Thank you for your help. Your publication will be a great asset to my work.

Donna M. Wilson
Juvenile Services Administration
Glen Burnie, Maryland

Prof Marsden is appointed to the Senate

TORONTO — Canadian Prime Minister Pierre Trudeau has appointed Lorna Marsden, a vice-provost for the University of Toronto and a member of **The Journal**'s Editorial Board, to the Senate.

A professor of sociology, and chairperson of the Liberal Party policy committee, Dr Marsden is also a former member of the Ontario Committee on the Status of Women, a volunteer organization. She has written extensively on women's rights and says she hopes to have a particular involvement in Senate work relating to women and research in general.

Issues facing the Senate now, including legislation on equal pay, pension reforms, and the divorce act, are of specific interest to her, she said.

Dr Marsden joined **The Journal**'s Editorial Board in October 1978.

Marsden

Drug dangers, life-skills part of basic training

Recruits learn military attitude to drugs, alcohol

Canadian Forces recruits: at a stage where they need to experience success

CLEMETSPORT, NS — A series of drug-related incidents three years ago at Canadian Forces Base Cornwallis here, has led the Department of National Defence (DND) to add a comprehensive life-skills and stress management course to its ten-week recruit training program.

The discovery of the so-called "Cornwallis Connection" in 1981 prompted personnel officers and the Forces' Surgeon-General's staff to conclude that existing substance abuse programs were ineffective.

"We found the conventional lecture just wasn't getting through to our young recruits," says Lt-Col John Middleton, senior staff officer for personnel support at the Canadian Forces Training Establishment in Trenton, Ontario.

"They probably knew more about the subject than the lecturer, so we felt there was a need for a different, attitudinal type of approach."

The new course moves from a general focus on learning interpersonal skills, and stress management, to different aspects of drug and alcohol abuse.

The focus on personal communication and ways of resisting peer pressure is important, Lt-Col Middleton explains, because "you're dealing with adolescents who have probably spent all their lives watching television and haven't been brought up in as strict a family as some of the older sweats have."

Stress management and relaxation receive special attention because recruits "are under quite a strain in the melting pot of a recruit school."

In the alcohol and drug education sessions, recruits learn about physiological aspects of substance addiction and factors that make people turn to drugs and alcohol. In each instance, information is tied to Canadian Forces policy forbidding use of illicit drugs and excessive use of alcohol.

The result was a contract for Phillip Bromley, PhD, then of the University of West Florida in Pensacola, who ran similar programs at United States Navy facilities around the world. The initial contract went to Dr Bromley, says Lt-Col Middleton, because "we felt he had the right approach . . . he was the expert in doing it in a military context."

Although Dr Bromley's work with the US Navy involved secondary intervention with people who already had serious problems in substance abuse, Canadian officials asked him to develop a primary prevention drug and life-skills education program. After two years of trials, Cornwallis officials settled on a nine-unit program taking up 24 hours over a three-day period.

The course is presented by civilian personnel, partly because military staff weren't available, and partly to avoid confusing the atmosphere of a "rap" session with the discipline of a Master Corporal.

In the group sessions, "what we're really after . . . is values, attitudes, and beliefs as they relate to the military attitude to drugs and alcohol," Lt-Col Middleton says.

Almost 10,000 recruits have gone through the program in the past three years, and recruit training staff have taken part as well.

DND officials have also found the program pays for itself. At a cost of about $45 per recruit, "we're quite pleased, at least in a subjective way, with the way it's paying off," Lt-Col Middleton says.

A side benefit is recruits work together sooner in their training than they otherwise would — "about two weeks earlier," he notes.

Dr Bromley says a system of positive reinforcement is important in reaching recruits at the three-week point in their training.

"They're at a stage where they need to see and experience success," he notes. After three weeks of learning that they're "unprepared to defend self, country, or anything else," he says, "they're ready to consider that there may be better ways to learn."By placing a positive experience in the context of military training, Dr Bromley found, "it all just comes together as a well-orchestrated symphony."

He says his work for the US Navy, which began in 1974 with a budget of around $20,000, evolved into the biggest human service program in the American military. In 1980 it posted an annual budget of $7 million, courses at 45 bases around the world, and a capacity of 20,000 participants per year.

But the big advantage of the "Canadianized" program, he says, is in cost reduction. Partly because the US course involved servicemen and women with an established problem, the price per participant was in the $140 range.

With a new, $144,000 contract for the next fiscal year at Cornwallis, he hopes to incorporate his Life-skill Corporation in Canada and is also planning to translate the course into French for recruits at St Jean, Quebec.

EAPs need input of industrial psychologists

By Jon Newton

TORONTO — Industrial psychologists have a definite role to play in establishing effective Employee Assistance Programs (EAPs).

Jack Santa-Barbara, PhD, a psychologist with Corporate Health Consultants Inc, here, says "how clients are eventually dealt with and treated is, of course, the crux of any program, but I would also argue that as mental health practitioners we should be paying attention to how the EAP model impacts on the entire mental health care system."

He told the annual meeting of the Ontario Psychological Association: "I believe the kind of model we operate under will have an impact beyond a particular program in terms of whether it's bringing, for instance, new mental health resources to the community."

Dr Santa-Barbara said there is a vast range of issues to be considered by professional psychologists involved in setting up EAPs.

Target population, staff demographics, workforce characteristics, whether an immigrant population is involved, and whether employees are organized into unions are all important components.

Another consideration, he said, is that different companies have different goals. Some are people-oriented and want EAPs to serve not only as adjuncts to existing employee health services, but also as morale boosters and company benefits.

On the other hand, some firms are cost-conscious and want EAPs to reduce potential crisis situations.

"Inevitably, there will be resistance to a program which could come from many different areas," Dr Santa-Barbara continued. "Some supervisors will feel jealous that you can be nice to employees when they have to discipline them. The same kinds of feelings could be generated by union stewards, and of course there will be resistance from employees themselves — so there are ranges of the kind of resistance which have to be dealt with when a program is being, developed."

He highlighted three major models — EAPs acting as referral agents, EAPs providing direct counselling, and programs operating under the case-management principle.

The first often have non-professionals like former alcoholics involved, he said, and are generally "internal" programs using part-time staff. There are inherent dangers in this kind of situation, Dr Santa-Barbara said.

"I know, for instance, of one EAP which has a part-time person for something like 9,000 employees. Another has a full-time internal resource for about 20,000 employees, so there is often a vast difference in the ratios between the EAP person and the number of employees with whom he has to deal.

"The unions tend to support these kinds of models, and one of the reasons they've done so, I believe, is because of peer involvement. People are much more comfortable going to a colleague because it is less stigmatizing."

But problems can and do arise under this kind of arrangement. Non-professionals could clog the system by sending the wrong people to the wrong places. There is also the danger that "non-professionals tend to engage in a certain amount of direct counselling, which is generally beyond their mandate.

"This leads to all kinds of problems both professional and legal, and, because many EAP workers in this situation come from an Alcoholics Anonymous type of tradition, the program may be seen as — and may, in fact, only be — an alcohol-(oriented) EAP."

The direct counselling model, on the other hand, may involve a number of different kinds of professionals, he said. There can be internal and external resources and the individual involved in the EAP could be part of the company medical department, or an outside consultant.

"But often it's just a single individual," commented Dr Santa-Barbara, "and a potential difficulty with this kind of model is that the practitioner may not have the full range of skills necessary to bring to bear in terms of policy, procedures, and the organizational types of issues which may come up in terms of promoting the program.

"And there is the danger of practitioner burn-out because the same individual has to do everything."

A very positive aspect of direct counselling, however, is that it is more likely to bring professional expertise to a situation. Companies are much more likely to pay attention to an EAP in this context because they are paying for the service, he said.

The case-management model involves matching the client with existing resources and coordinating services to discover a client's support motivation on an on-going basis.

"Some of the advantages of this kind of system are that it can facilitate utilization of existing resources within the community because you have professionals doing case management."

However, the case-management model depends on getting the right person the right therapy, so appropriate matching is vital to the system's efficiency, Dr Santa-Barbara added.

Support, respect of staff vital to program success

TORONTO — Achieving a rapport with employees and gaining their respect are two ingredients vital to the success of any Employee Assistance Program, an industrial psychologist told the Ontario Psychological Association meeting here.

"As an EAP counsellor, you need to get out and spend time with people on an on-going basis," said Warren Shepell, PhD, of Warren Shepell and Associates Inc, a private consulting firm. "You cannot be named an academic, or seem to be aloof and uninvolved."

But equally important, said Dr Shepell, is the preparation of any EAP.

"There is a lot of training involved," he said. "Workshops are needed and information sessions have to be set up and, finally, research skills are needed which a variety of psychologists can bring to EAPs.

"But you also need to understand organizational charts, and you have to have a good appreciation of key personnel — in other words, those individuals who are the power-brokers, decision-makers, and who are going to support the organization in implementing the EAP."

NEWS

Life-skills training curbs parolees' drug abuse

By Anne Kershaw

TULSA — An Oklahoma program for drug addicted and alcoholic prisoners about to be paroled is aimed at teaching them new life-skills to prevent their return to drug dependency on release.

And, on psychological tests at least, participants in the program are showing improvement.

Implemented in 1982 by the Oklahoma department of corrections, the Chemical Abuse Program is a departure from the traditional medical model or therapeutic approach to treating people with alcohol and drug addiction. The primary thrust of the treatment is to provide information and skills for everyday living.

Robert Briody, PhD, a forensic psychologist with the department of corrections, says nearly all participants have been diagnosed as having a personality disorder.

Inmates who are referred to the program — men within 18 months of parole and who are not diagnosed as schizophrenic, psychotic, or mentally retarded — work in groups of 15 on a 12-week cycle.

Dr Briody told **The Journal** the success of the program can really be measured only in terms of how many participants are able to return to society without resorting to drugs or alcohol as a crutch.

A recidivist follow-up study is planned in about six-months, Dr Briody said.

Psychological testing used to measure the effectiveness of the program showed inmates who completed the program were less depressed, less anxious, less confused, and more in control of their emotions following treatment.

At the time of arrest, 1% of the prisoners were cocaine abusers, 14% were opioid dependent, 15% were alcohol dependent, 32% abused amphetamines, and 33% abused barbiturates. Many of the participants were cross-addicted. As well, 77% reported excessive use of alcohol and 72% said they had used cannabis on at least a weekly basis.

In the first year, of 95 inmates who were accepted into the chemical abuse program; 51% completed all aspects of the program, 13% were removed for administrative reasons, 15% failed to perform satisfactorily, and 21% were disqualified for using some form of drug during treatment.

Since then, 43 more have completed the program and 52 inmates have been accepted into the next 12-week cycle.

The program includes:

- Behavior training (30 hours) — this course teaches methods for learning impulse control.
- Interpersonal communication skills (70 hours) — participants learn listening skills and how to respond empathetically to others.
- Group therapy (20 hours) —participants discuss expectations for future behavior and the ineffectiveness of past behavior.
- Assertiveness training (24 hours) — a behavioral approach is used to moderate aggression and promote acceptable social skills.
- Stress management (24 hours) — participants learn relaxation techniques and methods for identifying sources of stress.
- Values clarification (nine hours) — participants learn how former behavior has prevented them from attaining their goals.
- Family re-integration (15 hours) — problems connected to returning to the family upon release are identified and possible solutions explored.
- Drug abuse education (45 hours)— lectures, tapes, films, and discussion are used to illustrate the manipulative behavior of the addict and to identify the physical, social, and psychological consequences of abuse.
- Individual counselling (as requested).
- Staff discussions — every Friday is set aside for staff to discuss the progress of each participant. Participants whose progress is not satisfactory are transferred back to a high-security setting.

Fitness, economy play role in rise of UK abstainers

LONDON — Despite the escalation of problem drinking in Britain, there seems also to be growth in the ranks of abstainers.

The Ansvar Insurance Company, which specializes in insurance for non-drinkers, claims the number of non-drinkers has gone up by 30% in the last four years.

The biggest increases were in the 18- to 24-year age group where the percentage of non-drinkers went up to 6% from 3%, and among those aged 65 and older where the percentage went up to 26% from 18%.

The company noted the largest concentration of non-drinkers was among women 65 years and older; 34% of them abstained.

Ansvar's managing director, Geoffrey Williams, said the statistics were based on figures issued by the department of Health and Social Security which showed that in 1982, 12 people in every 100 were non-drinkers. In 1978, the figure had been nine in every 100.

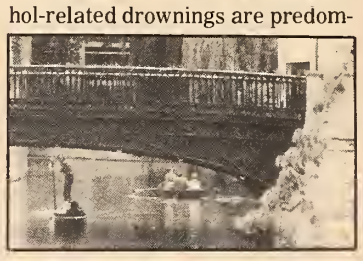
"There is general evidence of a marked upswing in the number of non-drinkers," Mr Williams said. Growing interest in fitness and diet, pressure on household budgets, and stricter drink-drive laws were the likely explanation, he said.

Intoxication is largest factor in British drowning deaths

LONDON — Alcohol is the largest single factor in drowning accidents, the Royal Life Saving Society (RLSS) has reported here.

Of the 516 drownings recorded during 1982, almost one quarter were associated with drinking, the society says.*

RLSS director Keith Sach told **The Journal**: "It seems that alcohol-related drownings are predominantly a male problem which has its peak in the 15- to 24-year age group.



"This is the same with alcohol problems on our roads and with football fans, so it does underline the need for urgent attention to a growing social phenomena."

Later, Mr Sach told a conference at the Royal Free Hospital that nearly 43% of the drownings (in which alcohol was apparent) occurred in rivers, and a further 16% happened in the sea.

**Drowning in the British Isles, 1982*, published by the Royal Life Saving Society, Mountbatten House, Studley, Warwickshire, Eng B80 7NN, £2.

Self-rolled cigarettes are found to have higher toxin levels

OTTAWA — Smokers switching from manufactured cigarettes to cheaper, hand-rolled cigarettes may be getting more tar, nicotine, and carbon monoxide than they thought.

Although cigarette sales in Canada fell by 4% in 1983, Health and Welfare Minister Monique Begin said she is concerned about recent increases in the sale of fine-cut tobaccos (used in hand-rolled cigarettes), which now account for 10% of the market.

Ms Begin said consumers are not adequately informed of the tar, nicotine, and carbon monoxide yields of these products.

A recent analysis of 13 popular brands of fine-cut tobacco by Labstat Inc (**The Journal**, June 1980) was compared with the yields from corresponding manufactured cigarettes.

"For all brands that were compared, the yields of tar and carbon monoxide from the fine-cuts were markedly higher than from their manufactured equivalents, in some cases four or five times higher," Ms Begin said. "The fine-cut tobaccos also yielded up to three times as much nicotine."

Ms Begin has asked the Canadian Tobacco Manufacturers' Council (CTMC) to list the yields per cigarette on advertisements and packages of fine-cut tobacco.

Meanwhile, Ms Begin said the CTMC has agreed to make a number of other changes on labelling and advertising practices. The current health warning, "Health and Welfare Canada advises that danger to health increases with amount smoked —avoid inhaling," and relevant tar and nicotine yields will appear on:

- all cigarettes of foreign manufacture imported and distributed by CTMC companies in Canada;
- all packages of cigars made or imported by CTMC companies;
- all pipe tobacco packages;
- all cigarette carton wrappers; and,
- on all cigarette billboards.

Average yields of selected toxic substances from cigarettes made with fine-cut tobacco and the corresponding brand of manufactured cigarette, Canada — 1983

Brands	Fine-cut Tobacco			Manufactured cigarette		
In decreasing order of tar differences	Tar	Nicotine	CO	Tar*	Nicotine*	CO
Matinee Extra Mild	19	1.1	23	4	0.4	5
Craven A Special Mild	18	1.2	22	4	0.4	5
Export (A) Light	22	1.3	22	10	0.8	14
Gitanes	20	0.9	24	10	0.5	16
Matinee	21	1.4	21	11	0.8	14
Craven A	20	1.5	21	12	1.0	12
Belvedere	21	1.3	23	15	1.1	16
Players Light	20	1.3	22	15	1.1	17
Players	21	1.4	23	16	1.2	18
Export (A)	22	1.3	22	17	1.1	16
Mark Ten	20	1.2	24	16	1.1	18
Embassy	22	1.4	21	NA	NA	NA
Drum	27	1.7	24	NA	NA	NA

*Values printed on the package.

NOTE: *Fine-cut tobaccos were made into cigarettes using commercially available filter tubes and rolling devices, then smoked by machine. Although weights of fine-cut cigarettes varied more than did those of the corresponding manufactured variety, the tabulated comparisons are valid as averages on a "per cigarette" basis.*

Billboards violate ad code anti-smoking lobby claims

By Terri Etherington

TORONTO — A non-smokers group here has called for an end to what it calls "the fox guarding the chicken coop" with respect to a voluntary code on advertising, agreed to by Canadian tobacco manufacturers.

In a press conference timed to coincide with a protest over tobacco-sponsored sporting events for young people, (see page 1 and The Back Page) the Toronto-based Non-Smokers' Rights Association (NSRA) claims there have been 45 violations in Toronto of the Canadian Tobacco Manufacturers' Council (CTMC) voluntary code restricting placement of cigarette billboards near schools. More than 200 violations were later reported in a survey of seven other Canadian cities.

David Sweanor, lawyer for the NRSA, believes the billboards ignore the voluntary ban on such ads within 200 metres of a public or high school.

Garfield Mahood, NSRA executive director, said the violations of this section of the code "clearly show there is need for legislation. Right now they (the tobacco companies) are hard pressed, and they are prepared to violate their codes, to push to the limit, to stabilize their sales."

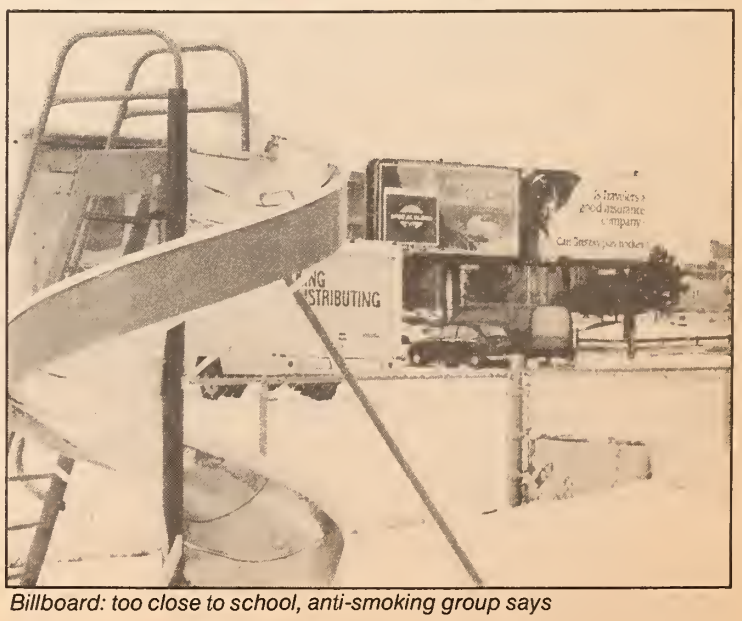
Jacques LaRivière, spokesman for the CTMC in Montreal, told **The Journal** he knows of only two complaints concerning this section of the code in the past five years.

In both cases, he said, the billboard was removed immediately.

Mr LaRivière says, however, ensuring that billboards are not placed near schools is a "shared responsibility."

While "the ultimate responsibility rests with the advertiser or member company . . . the billboard companies are well aware of the specifications and they have a responsibility."

Michael Finnegan, executive vice-president of Mediacom, one of Toronto's largest billboard companies, says his company is reviewing the list of 45 Toronto violations outlined by the NSRA. "It is our determination to work within that code and if there are violations we will change them."



Billboard: too close to school, anti-smoking group says

Teachers' manual: unhealthy products particularly fair game

Kids enlisted in war on misleading ads

SYDNEY — Australia's BUGA UP — Billboard Utilising Graffitists Against Unhealthy Promotions — has launched a campaign encouraging school children to "redesign" magazine advertisements revealing contradictions or untruths in advertisements.

BUGA UP is an informal group of Australians known mainly for arming themselves with spray paint and defacing tobacco billboard ads (The Journal, July, Nov 1983).

Some opposition party members in the New South Wales parliament have criticized the group for inviting children to deface the advertisements; the Australian Advertising Industry Council is also up in arms. But the additional publicity has made the project — called Ad Expo — even more popular, say the anti-smoking activists.

Last year they sent Ad Expo manuals to teachers, asking them to pass the documents on to students.

"There are no restrictions on . . . subject matter, so long as the participant explains why it is unhealthy," says the manual. "Unhealthy products, lifestyles, sexist or racist stereotypes are the mainstay of the advertising industry and are thus particularly fair game."

The best submissions will be chosen based on their humor, artistic merit, and standard of written criticism. No prizes are offered, but the best entries will be exhibited publicly and produced later in book form.

Antenatal warning vetoes alcohol

LONDON — Pregnant women — and those contemplating pregnancy — have been given a new warning that they should avoid alcohol.

Peter Davis of the Warneford Hospital, Leamington Spa, addressing an Institute of Alcohol Studies conference at the British Medical Association headquarters, said 973 white women attending an antenatal clinic completed a questionnaire on parity, social class, smoking habits, and consumption of alcohol and coffee.

None of the 49% who said they were non-drinkers had a baby with a major congenital abnormality. In contrast 1.2% of the babies of the drinking women were born with abnormalities.

Women who said they drank more than an average of 20 ml alcohol daily had babies with significantly smaller head circumferences than those of non-drinkers.

Lower yields offset by inhalation

Cancer expert wants stronger cigs

HEIDELBERG, Germany — A cancer expert here wants his government to make it illegal for tobacco manufacturers to sell anything but cigarettes with high nicotine yields.

The surprising plea comes from Professor Ferdinand Schmidt of the University of Heidelberg who said in the German *Medical Tribune* that people who use low nicotine brands try to satisfy their cravings by smoking more and inhaling more deeply.

"Fewer people smoke more," he said. "The average European smoker's consumption has increased from 13.5 cigarettes per day in 1960 to 19.4 in 1979." Deaths from lung cancer have increased, "although harmful substances in cigarettes have been reduced by more than half during the period of 1961-75 . . . and since then by another 36%," he continued.

"The conclusion is all but inevitable: significant reductions in nicotine content affect the smokers as they suffer from nicotine addiction." And inhalation is more of a factor in smoking than nicotine content, he added. A reduction by as much as 50% of the nicotine content can be easily compensated by a 1% higher inhalation frequency, Dr Schmidt said.

NZ children: 90% have tried drink

AUCKLAND, NZ — A study of nine-year-old New Zealand children showed more than 90% had tasted alcohol. Nearly half considered that drinking causes only "negative" effects, such as drunkenness.

In interview responses closely corroborated by separate interviews with mothers, three-quarters of the 743 children involved said they had tried drinking alcohol; a further 18% had tasted a sip. Only 7% had not tasted alcohol.

About 6% said they typically "had a sip" or drink at least once a week, one-quarter at least once a month, and 79% once a year. But one-quarter reported that they had had a drink in the past week, and almost half reported drinking within the last month, suggesting a higher level of frequency.

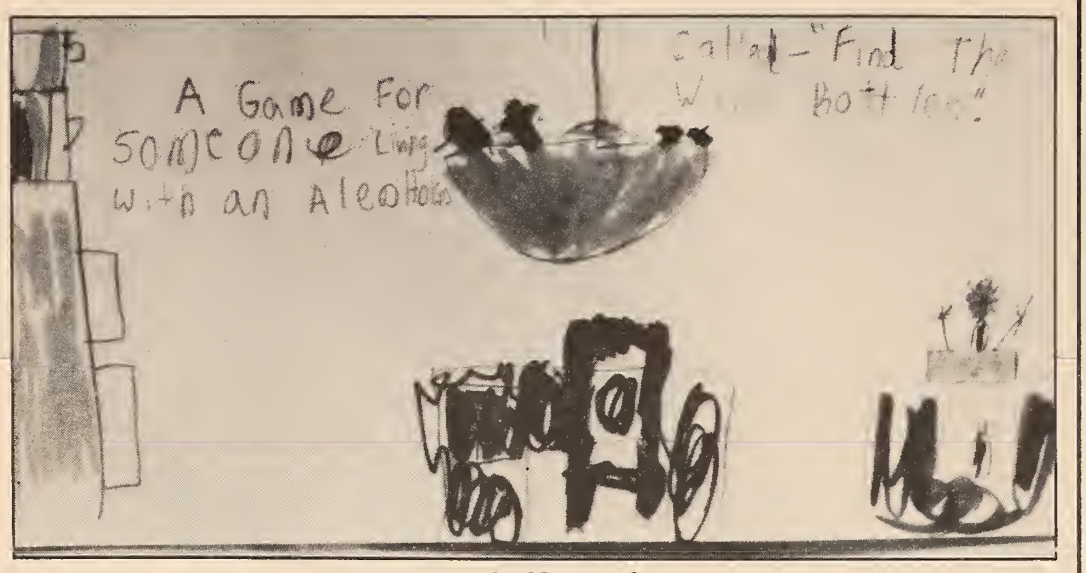
The study, published in the *New Zealand Medical Journal*, was conducted in Dunedin by researchers from the Alcohol Research Unit at Auckland University and the Multidisciplinary Health and Development Research Unit at Otago University.

The most common setting for the first alcohol experience was with one or both parents present; 95% of the children who had tasted alcohol had their first drink with their parents, and more than two-thirds said their father gave them the drink.

Asked "what happens to people who drink?" almost three-quarters of the children reported drunkenness, 27% reported specific results of heavy intake such as vomiting, fighting, clumsiness, and dizzyness, and 28% mentioned an effect to do with driving.

Only 9% mentioned effects which might be considered pleasant.

NEWS



A child's view

"A game for someone living with an alcoholic" . . . that's how a nine-year-old child captioned this drawing — bottles stashed in a chest of drawers, in the light fixture, in a flowerpot. The picture comes from *Images within — a child's view of parental alcoholism*, part of a touring exhibition organized by New York's Children of Alcoholics Foundation. The display is scheduled for presentation in Providence, Rhode Island, and Boston in March.

Drug users have more problems at school

PHILADELPHIA — Marked differences between high school drug-using, and drug-free students in peer counselling because of school problems, have been revealed in a new study.

Drug-users were more likely to be runaways, suffer from lack of motivation at school, have been suspended or expelled, have spent more time "goofing off" and sleeping, and have more need for help with vocational training and problem solving. They also spent less time reading, participating in religious activities, and doing homework.

The findings came from a Youth Needs Assessment Inventory Instrument administered by the Philadelphia Psychiatric Center in two high schools here. Subjects were 419 volunteer students in grades 9, 10, and 11; 43% were male and 57% female. Sixty-four percent were white, 33% black and 3% other.

Significant differences were noted among four demographic variables between drug-users and non-users. These were age, sex, race, number of times picked up by police, and whether they had been arrested and jailed.

The drug-users were older, there was a higher proportion of whites, and more had brushes with the criminal justice system.

They also were less likely to seek professional help; spent less time watching television; and were more satisfied with their friends and their social life.

Liquor sale profits eyed for NB treatment budget

FREDERICTON — Federal funding enabled the New Brunswick Alcohol and Drug Dependency Commission (ADDC) to spend more money and reach more people in fiscal 1982-83 than ever before, says its fifth annual report.

Nevertheless, ADDC chairman Everett Chalmers, MD, says the budget can't meet demand for treatment services. The NB government is being asked to consider the profits of the provincial liquor corporation to assist the ADDC.

The motion, to that effect, was passed in the Public Accounts Committee of the NB Legislature two weeks after the release of the report.

Dr Chalmers told the accounts committee there are an estimated 20,000 alcoholics among the approximately 700,000 New Brunswickers. He underlined his concern about the shortage of facilities saying 120 people had been turned away from a 13-bed detox centre in Moncton in a four-month period. Thirty-one of those turned away were first-time cases. (**The Journal**, Feb)

Liberal opposition members in the NB legislature had asked originally that at least 10% of the New Brunswick Liquor Corporation's (NBLC) profits should be earmarked for the ADDC. Profits for the liquor corporation reached $58.2 million in 1982-83. However, NBLC chairman B.L. Kinney told the accounts committee that profits are transferred to the general provincial revenues. Allocation of any or all of the funds is a political decision beyond the mandate of the NBLC, he said.

Total ADDC expenditures for the year ending March 31, 1983, reached $5,284,563, up 16.27% from $4,544,956 in 1981-82 (**The Journal**, Dec 1982). Provincial government contributions fell by 2.87% to $3,264,091. But the federal government provided a 70.6% grant increase, bringing its total to $2,020,472.

With the increased federal funding the ADDC was able to open two extra facilities — an in-patient service for French-speaking women in Campbellton, and a co-ed centre at Edmundston.

The addition of the two new centres gave the ADDC a total of 196 beds. Rehabilitation admissions at Campbellton, Ridgewood, and Lonewater Farm increased by 9% to 625. Treatment admissions increased by 3.9% to 3,220.

Employee assistance programs (EAPs) continued to expand as 10 more companies opened in-house treatment plans. Twenty-seven companies which have developed programs since 1978 took part in a study to help formulate EAP strategy for the province. Fifty-one companies and unions have worked actively in EAP promotion.

In addition, a student assistance program with an EAP-based philosophy is in the pilot stage and will likely be promoted throughout the school system in the province.

The ADDC also continued a program of presentations to students and educators, in line with Dr Chalmers' view that education about the dangers of alcohol and drug use is the long-term key to combatting abuse.

Alcohol an extra burden for combat veterans

ATLANTA — Many Vietnam veterans who are alcoholics need to know they may also be suffering from combat fatigue.

Although alcoholism is their primary problem, identifying post-traumatic stress can assist in treatment, said William Griffith, formerly medical director, Chemical Dependency Recovery Center, Hillside Hospital, San Diego, Cal.

He said: "Post-traumatic (combat fatigue) stress is not the primary thing. People die of alcoholism, but I don't know anybody who has died of post-traumatic stress." Dr Griffith saw combat with the United States Marines in Vietnam and found: "I didn't recognize it in myself; my friends did."

He told the Southeastern Conference on Alcohol and Drug Abuse here: "We in treatment address anything and probe such things as sex history, crime, or child abuse, but very rarely do we want to probe into war."

Counsellors need to get as much information as possible from veterans, and if they don't feel competent to do it, veterans' centres, located in every state, have experts who know how to help, he said.

Dr Griffith, a recovering alcoholic, said people should realize "there is nothing more exciting than war." In combat "lots of things are going on, people are dying, life and death decisions have to be made immediately."

And combat leaves its mark. "Anything less than that for me was just that — less than that. It became increasingly difficult for me to feign panic over the mundane. It makes it difficult to do jobs sometimes, especially when you have questions about authority."

Today, he said, he is opposed to anything to do with death, and because he dealt with stress in group sessions with other veterans, where they talked about comrades' experiences, his life now is not as disturbed.

Dr Griffith said treatment is initially aimed at dealing with alcoholism. If veterans come in for treatment a second time, "we focus on the post-traumatic stress itself as it seems to be the question to be resolved."

Vietnam combat veteran Skip Mitts, executive director of Goodman Hill Hospital, Paducah, Kentucky, said it is necessary to do histories on veterans. "We need to know where they served, if it was in Vietnam, whether they were in combat, and how many times they were wounded or decorated."

Those with the problem never talk about combat experiences, he said.

Another clue to those with stress is to note their reaction if asked: " 'How did you respond when the president (Jimmy Carter) pardoned the draft evaders?' They are furious about that," Mr Mitts added.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. For further information, contact Margaret Sheppard at (416) 595-6150.

Substance Abuse: Management Intervention

Number: 592.
Subject heading: Employee assistance programs.
Details: 17 min, 16mm, color.
Synopsis: Jack is in a management position in a manufacturing company. His work performance is down, he has difficulty dealing with those under him, and he is keeping irregular hours. The narrator urges Jack's boss to consider an intervention other than firing him, as Jack has a lot of valuable experience and could not easily be replaced. The first time the confrontation takes place, Jack's boss accuses him of drinking excessively and Jack responds with hostility. The narrator tells the boss to try again, with full documentation and no mention of drinking. This time Jack agrees to get help.
General evaluation: Fair to good (3.7). This film is a good teaching aid to show small businesses how to deal with problem employees at the middle management level.
Recommended use: Employee assistance programs could benefit with a resource person to lead a discussion.

The Caffeine File

Number: 593.
Subject heading: Caffeine.
Details: 14 min, 16mm, color.
Synopsis: This spoof on spy movies has a secret agent investigating caffeine. He researches the history of caffeine and its pharmacology. He learns that it is a stimulant drug. Everywhere he looks he finds caffeine. He realizes it is addictive and cautions everyone, especially pregnant women, to reduce their consumption. However, even though he is going to stop drinking coffee and cola, and not use pills containing caffeine, he is not going to give up his chocolate.
General evaluation: Good (4.2). This satire has a clear message and is technically well-produced.
Recommended use: With a resource person, it could benefit 12- to 15-year-old students in nutrition classes.

Alcohol and Drugs: Know What You Are Doing

Number: 594.
Subject heading: Drugs and youth, youth and alcohol.
Details: 17 min, 16 mm, color.
Synopsis: A young girl feels left out; a boy believes he is a poor basketball player, another girl thinks she cannot do math. Three ex-drug users come to visit the school to tell the children drugs are not the answer to problems. They tell about their experiences and how great it is to be drug-free. The children are urged to find things they enjoy so that saying "no" to drugs will not be so difficult.
General evaluation: Poor (2.4). The format of the session with the ex-drug users makes the film boring. The children's questions and responses seem staged.
Recommended use: None.

EAP: A Supervisor's View

Number: 596.
Subject heading: Employee assistance programs (EAPs).
Details: 5 min, color.
Synopsis: A reporter interviews several supervisors about EAPs in their companies. They discuss how their policies are supposed to work so that supervisors do not get involved in personal problems.
General evaluation: Fair (3.0). As a public relations film for EAP policies this is fine. However, the audio-visual assessment group is uncertain as to its intended target.
Recommended use: With a resource person, the film might be used for middle-management in companies considering the implementation of EAPs.

DEPARTMENT

New Books

by RON HALL

Consequences of Drinking:

Trends in Alcohol Problem Statistics in Seven Countries

. . . edited by Norman Giesbrecht, Monique Cahannes, Jacek Moskalewicz, Esa Österberg, and Robin Room

This collection of papers describing and analyzing post-war trends in alcohol problems in seven industrialized societies is one of the products of the International Study of Alcohol Control Experiences (ISACE). Numerous manuscripts were prepared for the project and presented at the four working meetings held between 1978 and 1981. These ranged from conceptual papers through research notes to background material for chapter drafts of the main volumes — *Alcohol, Society and the State*. The papers presented in this volume are generally similar in theme, approach to the data, and type of data series used. However, they differ in their emphasis, presentation of data, interpretation, and specific conclusions drawn. A common theme is that indicators of alcohol damage have generally increased during the post-war era. Alcohol-related problem indicators are selected from mortality, morbidity, police and court statistics, and traffic accident data. The papers are intended to encourage further analysis and research on the selection of appropriate indicators of damage, and documentation of their relevance as indirect barometers of alcohol consumption, actual incidence and prevalence of damage, and the impact of control and rehabilitation activities. The papers are presented as a resource for policy considerations and the development of appropriate interventions.

(Addiction Research Foundation, Marketing Services, Dept JR, 33 Russell St, Toronto, ON M5S 2S1. 1983. 145 p. $20. ISBN 0-88868-080-5)

Message in a Bottle:

Theoretical Overview and Annotated Bibliography on the Mass Media and Alcohol

. . . by Nicholas Dorn and Nigel South

This text provides a review of theories about mass media and their actual and potential application to communication about alcohol. It is based on the reading of 404 articles, reports, books, and previous reviews of the complex relations between the mass media, their audiences, and the images and messages they carry about alcohol. The annotated bibliography contains abstracts of the sources reviewed. The authors review three principal 'types' of media theory, followed by criticisms and alternative perspectives based on recent work in cultural studies. The discussion is concerned with the practical and theoretical problems arising out of recognition of the inadequacy of any conception of the media as having straight-forward effects upon levels of alcohol consumption.

(Gower Publishing, Old Post Rd, Brookfield, VT 05036. 1983. 178 p. $29.95. ISBN 0-566-00621-9)

Other books

Alcohol and Sexuality: An Annotated Bibliography on Alcohol Use, Alcoholism, and Human Sexual Behavior — O'Farrell, Timothy J. and Weyand, Carolyn A. Oryx Press, Phoenix, 1983. Effects of alcohol use and abuse on sexual function; nature and treatment of sexual problems among alcoholics; social problems and cultural issues relating to alcohol and sexuality; literature review; 542 citations. Index. 131p. Oryx Press, Ste 103, 2214 N Central at Encanto, Phoenix, AZ 85004. $37.50. ISBN 0-89774-040-8.

Alcoholism, Narcissim and Psychopathology — Forrest, Gary G. Charles C. Thomas, Springfield, 1983. Alcoholism and anxiety; avoidance defence system; depression and oral rage; identity; paranoia; acting out; guilt; obsessive-compulsive disorder; adaptation. Bibliography, index. 308 p. Charles C. Thomas, 2600 S 1st St, Springfield, IL 62717. $28.50. ISBN 0-398-04815-0.

Narcotics and Reproduction: A Bibliography — Abel, Ernest L. Greenwood Press, Westport, 1983. 1,891 citations of materials dealing with the effects of the use of heroin, morphine, methadone, and related narcotic drugs on reproduction; titles are arranged by author; subject index. 215 p. Greenwood Press, 88 Post Rd W, Box 5007, Westport, CT 06881. $29.95. ISBN 0-313-24052-3.

A Call to Action: Youth, Alcohol and Other Drugs — Attridge, Terry. Office of Substance Abuse Ministry, New York, 1983. A community approach to education, prevention, and intervention. 154 p. Office of Substance Abuse Ministry, Catholic Center, 1011 1st Ave, New York, NY 10022. $6.95.

CPDD conference calls for papers

TORONTO — The Committee on Problems of Drug Dependence (CPDD) is seeking scientific papers on alcohol abuse for its 46th annual scientific meeting in St Louis, Missouri, June 4-6.

In the past, the CPDD has placed heavy emphasis on opiate addiction, but now there is a wider interest in alcohol problems, says Harold Kalant, MD, PhD. He's the Addiction Research Foundation's (ARF) permanent liaison with the committee and director of neurobiology at the ARF.

Plenary speaker will be David Van Thiel, MD, professor, department of medicine, University of Pittsburgh School of Medicine. Dr Van Thiel will discuss endocrine effects of alcohol and other drugs.

A small number of travel-scholarships will be made available to post-doctoral fellows on the recommendation of their research supervisors, Dr Kalant said.

For further information, contact: Joseph Cochin, MD, department of pharmacology, Boston University School of Medicine, 80 Concord St, Boston, Massachusetts 02118.

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DEPARTMENT

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Dementia — Practical Techniques in Caring for People Affected by Cognitive Losses — March 5, Toronto, Ontario. Information: Carrie Andrews, Project Coordinator, Professional and Management Development, Humber College, 205 Humber College Blvd, Rexdale, ON M9W 5L7.

Detox Training Program (Non-Medical) — March 5-9, April 30-May 4, Toronto, Ontario. Information: Diane Hobbs, Detox and Rehab Programs, Addiction Research Foundation (ARF), 33 Russell St, Toronto, ON M5S 2S1.

A Basic Orientation to Addiction for Nurses — March 6-April 24, Toronto, Ontario. Information: Rose Antonio, Continuing Education Program, University of Toronto, Faculty of Nursing, 50 St George St, Toronto, ON M5S 1A1.

Circuit and Rural Court Justice in the North — March 11-16, Yellowknife, Northwest Territories. Information: The Northern Conference, c/o Continuing Studies, Simon Fraser University, Burnaby, British Columbia V5A 1S6.

Instructional Methodologies Course — March 12-16, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

1984 National Health Care Management Conference, The Challenge of Change — March 19-20, Toronto, Ontario. Information: Ingrid Norrish or Jill Birch, Professional and Management Development, Humber College, Professional Services, 205 Humber College Blvd, Rexdale, ON M9W 5L7.

Dynamics of Physical Assessment — March 22-23, Toronto, Ontario. Information: Gail Summers, Senior Program Coordinator, Health Sciences division, Osler Campus, Humber College, 5 Queenslea Ave, Weston, ON M9N 2K8.

American Orthopsychiatric Association 61st Annual Meeting — April 7-11, Toronto, Ontario. Information: The American Orthopsychiatric Association, 19 W 44th St, Ste 1616, New York, NY 10036.

Research 84: Understanding the Nature of Nursing Through Research — April 13, Toronto, Ontario. Information: Rose Antonio, Continuing Education Program, University of Toronto, Faculty of Nursing, 50 St George St, Toronto, ON M5S 1A1.

Public Drinking and Public Policy: A Symposium on Observation Studies — April 26-28, Banff, Alberta. Information: Eric Single, Addiction Research Foundation, 33 Russell St, Toronto, Ontario M5S 2S1.

1984 Canadian Addictions Foundation Atlantic Regional Conference, Families and Drug Dependencies New Problems, New Challenges — April 29-May 3, Halifax, Nova Scotia. Information: Nova Scotia Commission on Drug Dependency, Ste 314, Lord Nelson Bldg, 5675 Spring Garden Rd, Halifax, NS, B3J 1H1.

Addictions Extravaganza — May 5-6, Regina, Saskatchewan. Information: Lorri Hovland, Addictions Ex, 728 Broad St N, Regina, SK S4R 7B5.

Introductory Addictions Management Course — May 14-16, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

The 6th Institute of the Section on Women and Psychology (SWAP) of the Canadian Psychological Association — May 30, Ottawa, Ontario. Information: Dr Katherine Schultz, department of Psychology, University of Winnipeg, 515 Portage Ave, Winnipeg, Manitoba, R3B 2E9.

25th Annual Institute on Addiction Studies — July 15-20, Hamilton, Ontario. Information: Karl N. Burden, Course Director, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

Summer Fundamental Concepts Course — July 16-19, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Canadian Society of Forensic Science 31st Annual Conference —Aug 18-24, Winnipeg, Manitoba. Information: Executive Secretary, Canadian Society of Forensic Science, 171 Nepean St, Ste 303, Ottawa, Ontario K2P 0B4.

1984 Annual Convention of the American Psychological Association — August 24-28, Toronto, Ontario. Information: American Psychological Association, 1200 17th St, NW, Washington, DC 20036.

5th Annual Meeting, Canadian Group Psychotherapy Association — Oct 17-20, Ottawa, Ontario. Information: Edwardo Perez, MD, department of Psychiatry, Civic Parkdale Clinic, 3rd floor, Ottawa Civic Hospital, 737 Parkdale Ave, Ottawa, ON K1Y 4E9.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-9, 1985, Calgary, Alberta. Information: Jan Skirrow, Chairman, 34th ICAA Congress, AADAC, 6th fl, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

United States

"The Images Within: A Child's View of Parental Alcoholism," An Exhibit of Art by Children of Alcoholics — March 1-15, Providence, Rhode Island and March 20, Boston, Massachusetts. Information: Children of Alcoholics Foundation, 540 Madison Ave, 23rd fl, New York, NY 10022.

3rd Annual Prevention Symposium — March 8-9, Anchorage, Alaska. Information: Claudia S. Brunner, Alaska Council on Prevention of Alcohol and Drug Abuse, Inc, 7521 Old Seward Highway, Ste A, Anchorage, Alaska 99502.

Marketing the Alcoholism Treatment Program — March 8-9, New Orleans, Louisiana. Information: Vicki Kotecki, Manager, Administrative Services, NAATP, 2082 Michelson Dr, Ste #200, Irvine, California 92715.

The Effect of Maternal Alcohol Use and Alcohol-Related Problems on Inter-Uterine Growth and Apgar Scores — March 23, Buffalo, New York. Information: Research Institute on Alcoholism, 1021 Main St, Buffalo, NY 14203.

4th Annual Atlantic City Conference on Education and Prevention Training — March 25-28, Atlantic City, New Jersey. Information: National Council on Alcoholism of Ocean County, 528 River Ave, Lakewood, NJ 08701.

Sexuality and Alcohol/Drug Dependence — March 26-28, Indianapolis, Indiana. Information: Kay F. Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

Economics of Alcohol Abuse — March 30, Buffalo, New York. Information: Research Institute on Alcoholism, 1021 Main St, Buffalo, NY 14203.

Joint Meeting of the Psychopharmacology Division of the American Psychological Association and the American Society for Pharmacology and Experimental Therapeutics — April 2-6, St Louis, Missouri. Information: Robert Balster, department of Pharmacology and Toxicology, Medical College of Virginia, Box 613, MCV Station, Richmond, Virginia 23298.

Ruth Fox Course for Physicians — April 12, Detroit, Michigan. Information: Claire Osman, Course Coordinator, American Medical Society on Alcoholism, 733 3rd Ave, New York, NY 10017.

National Alcoholism Forum of the National Council on Alcoholism — April 12-15, Detroit, Michigan. Information: Angela Masters, 733 3rd Ave, New York, NY 10017.

15th Annual Medical-Scientific Conference of the National Alcoholism Forum, "Clinical Applications of Alcoholism Research" — April 12-15, Detroit, Michigan. Information: Medical-Scientific Conference Coordinator, AMSA, 733 3rd Ave, 14th floor, New York, NY 10017

5th Regional Conference on Substance Abuse "Innovations in Prevention and Treatment" — April 18-20, Cincinnati, Ohio. Information: Ann Blankenhorn, Central Community Health Board, 532 Maxwell Ave, Cincinnati, OH 45219.

10th Annual School on Addiction Studies — April 30-May 4, Anchorage, Alaska. Information: Ken Duff, Center for Alcohol and Addiction Studies, UAA, 3211 Providence Dr, Anchorage, Alaska 99508.

Why It Works: An Appreciation of Alcoholics Anonymous — May 11, Milwaukee, Wisconsin. Information: Candee Brandis, Training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

"Provider Preparedness: 84" Annual Meeting of the National Association of Alcoholism Treatment Programs (NAATP) — May 14-17, Denver, Colorado. Information: Vicki Kotecki, NAATP Manager, Administrative Services, 2082 Michelson Dr, Ste 200, Irvine, California 92715.

Electrophysiological Markers of High-Risk for Alcoholism — May 18, Buffalo, New York. Information: Research Institute on Alcoholism, 1021 Main St, Buffalo, NY 14203.

3rd Annual Seminar on "Chemical Dependency: Issues in Treatment," — May 18-19, Asheville, North Carolina. Information: Jerry Bryson, Woodhill Drug and Alcohol Treatment Center, Appalachian Hall, PO Box 5534, Asheville, NC 28813.

National Conference on Women and Alcoholism — May 23-25, Seattle, Washington. Information: Dr Geri Marr Burdman, department Community Health Care Systems, SM-24, University of Washington, Seattle, WA 98195.

46th Annual Scientific Meeting of the Committee on Problems of Drug Dependence — June 4-6, St Louis, Missouri. Information: Dr Joseph Cochin, department of Pharmacology, Boston University, School of Medicine, 80 E Concord St, Boston, Massachusetts 02118.

Alcohol and Drug Problems Association (ADPA) 35th Annual Conference — Aug 19-23, Washington, DC. Information: Eric Scharf, Alcohol and Drug Problems Association, 1101 15th St, NW, #204, Washington, DC 20005.

5th Annual National Conference on Employee Assistance Programming — June 4-7, Kansas City, Kansas. Information: Bethany Medical Centre, The EAP Conference, 51 N 12th St, Kansas City, KS 66102.

Central States Institute of Addiction, Continuing Education Program on Addiction, 3rd Annual June Institute — June 11-15, Chicago, Illinois. Information: Stella Nicholson, or Mary Wannop-Catelain, Central States Institute of Addiction, 120 W Huron St, Chicago, IL 60610.

North American Conference on Alcohol and Highway Safety — June 12-14, Baltimore, Maryland. Information: Dr Patricia Santora, Program Director, Johns Hopkins University School of Medicine, 57 Turner Auditorium, 720 Rutland Ave, Baltimore, MD 21205.

35th Annual Symposium on Alcoholism — June 18-29, Seattle, Washington. Information: Alcohol Studies Program, Seattle University, Seattle, WA 98122.

2nd Congress of the International Society for Biomedical Research on Alcoholism — June 24-29, Santa Fe, New Mexico. Information: Richard A. Deitrich, department of Pharmacology, Alcohol Research Centre, University of Colorado, Health Sciences Center, 4200 E 9th Ave, Denver, Colorado 80262.

National Association of Alcoholism and Drug Abuse Counselor's Annual Conference — Aug 4-8, Indianapolis, Indiana. Information: NAADAC, 951 S George Mason Dr, Arlington, Virginia 22204.

18th Annual Association for the Advancement of Behavior Therapy Convention — Nov 1-4, Philadelphia, Pennsylvania. Information: John E. Martin, Program Chairperson, AABT/84, Psychology (116B), VA Medical Center, Jackson, Mississippi 39216.

2nd National Conference on Alcohol and Drug Abuse Programming for Colleges and Universities — Nov 11-14, Boston, Massachusetts. Information: Eric Scharf, Alcohol and Drug Problems Association, 1101 15th St, NW, #204, Washington, DC 20005.

Abroad

An International Conference on Alcoholism and Drug Addiction — April 2-7, Canterbury, England. Information: Conference Secretary, Broadway Lodge, Oldmixon Rd, Weston-super-Mare, Avon, BS24 9NN, England.

6th International Conference on Alcohol Related Problems — April 8-13, Liverpool, England. Information: Conference Secretary, MLCCA, 1st fl, The Fruit Exchange, Victoria St, Liverpool L2 6QU, England.

30th International Institute on the Prevention and Treatment of Alcoholism and the 14th International Institute on the Prevention and Treatment of Drug Dependence — Athens, Greece, May 27-June 2. Information: International Council on Alcohol and Addictions, Case postale 140, 1001 Lausanne, Switzerland.

3rd European Acupuncture and Alternative Medicine Symposium — June 1-3, Stockholm, Sweden. Information: Dr Anton Jayasuriya, Secretary-General, Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

15th World Congress of Rehabilitation International — June 4-8, Lisbon, Portugal. Information: National Secretariat for Rehabilitation, International Fair of Lisbon, Praca das Industrias, 1399 Lisbon-Codex.

III Congreso Iberoamericano sobre Alcoholism — June 19-22, Cuenca, Ecuador. Information: Centro de Rehabilitacion de Alcoholicos, Casilla 331, Ecuador.

Families with Alcohol Problems: Models of Intervention — June 26-29, Dublin, Ireland. Information: Monica McGoldrick, Family Training Program, UMDNJ-RMS-CMHC, Piscataway, New Jersey 08854.

3rd Biennial American University School of Justice Institute on Juvenile Justice —July 8-July 27, London, England. Information: Professor Richard A. Myren, Director, Institute on Juvenile Justice in England and America, School of Justice, The American University, Washington, DC 20016.

4th World Congress of Alternative Medicine — July 13-15, Amsterdam, Netherlands. Information: Dr Anton Jayasuriya, Secretary-General, Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

3rd International Conference on Treatment of Addictive Behaviors — Aug 12-16, North Berwick (Edinburgh), Scotland. Information: William R. Miller, department of Psychology, University of New Mexico, Albuquerque, New Mexico 87131.

Seminar on Addiction — Sept 6-14, Athens, Greece. Information: Darcy Edwards, Millglen Medical Corp, PO Box 888673, Atlanta, Georgia 30356-0673.

8th World Conference of Therapeutic Communities — Sept 16-21, Rome, Italy. Information: Charles J. Devlin, Executive Director, Daytop Village Inc, 54 W 40th St, New York, NY 10018.

International Congress on Alcohol Dependence, the Family, and the Community — Sept 16-22, Jerusalem, Israel. Information: International Congress on Alcohol Dependence, the Family, and the Community, Kenness International Inc, 1 Park Ave, New York, NY 10017.

11th International Conference of Social Gerontology — Oct 16-19, Rome, Italy. Information: International Center of Social Gerontology, 91, rue Jouffroy, 75017 Paris, France.

2nd Inter-American Symposium on Health Education — Nov 4-9, Acapulco, Mexico. Information: Symposium Steering Committee, c/o NARO, PO Box 2305, Station "D," Ottawa, Ontario K1P 5K0.

12th International Conference on Health Education — Sept 1-6, 1985, Dublin, Ireland. Information: Dr H. D. Crawley, Director, Health Education Bureau, 34 Upper Mount St, Dublin, Ireland.

Is it sporting?

Tobacco company sponsorship

Jon Newton reports from the Canadian ski-jumping championships in Thunder Bay

THUNDER BAY — Ottawa's Horst Bulau, 21, slides his skis back and forth, back and forth, at the mouth of the awesome 90-metre jump. High above the silent spectators, he concentrates fiercely in the bitter cold. Suddenly, explosively, he launches down the terrifying slope, capturing the Canadian 90-metre ski-jump championship for the second year straight.

His leap — 116.5 metres — also won him the Export "A" Cup, sponsored for the first time this year by the RJR-Macdonald tobacco company.

But there are people who would rather not talk about this.

For instead of being a national focus in preparation for the 1984 winter Olympics in Yugoslavia, the February championship meet here turned into a battle of wills (or won'ts) among the Canadian Ski Association (CSA), an informal coalition of people from anti-smoking and health bodies, and Health and Welfare Minister Monique Begin and the new Fitness and Amateur Sport Minister Jacques Olivier.

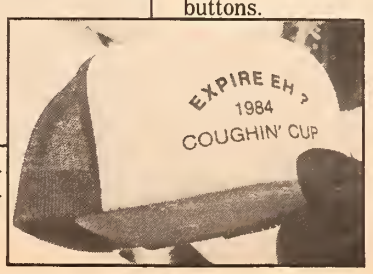
At the centre of the row — but on the sidelines of the battle — was the RJR-Macdonald tobacco company.

The ski-jump championships comprised the first public round in a fight between federal bureaucrats and anti-smoking lobbyists in one corner, and the CSA and RJR-Macdonald tobacco company in the other. At issue was the Macdonald sponsorship: the company has contracted to finance the events for the next five years to the tune of about $1.7 million.

On the face of it, the point being made by the health organizations is simple. Youngsters should not be exposed to cigarette advertising. And to bolster it, Ms Begin is going full tilt to discourage smoking.

"Sponsorships should not become a vehicle for promoting lifestyles that contain major health risks either among youth or among the population at large," she said in a statement released only two days before the start of the championships.

The stance was supported by various groups bent on forcing tobacco companies not to sponsor sporting events. The view was, and is, children could be induced to start smoking if they are exposed to intense advertising through games like this one — particularly when heroes (smokers, or otherwise) are involved.



Ski-patrol member: not enthusiastic about anti-smoking hats

And the coalition of individuals from the Canadian Cancer Society, the Canadian Council on Smoking and Health, the Toronto-based Non-Smokers' Rights Association (NSRA), the Canadian Heart Foundation, and two physicians from the CSA's own medical committee, used the championships to hammer home their message — Tobacco companies, stay away!

In the fore of the anti-smoking argument is Garfield Mahood, the zealous executive director of the NSRA. He, Andrew Pipe, a CSA team physician, and David Nostbakken, PhD, national director of public relations for the Canadian Cancer Society, held a press conference in Thunder Bay the day before the championships began.

The three told visitors, the media, townspeople, contest organizers, and representatives of the sponsor that, contrary to statements from Macdonald, the company was not supporting Canadian sport but was, in fact, encouraging youngsters to start smoking.

Dr Pipe said about 30,000 people die every year in this country from lung cancer, heart- and associated diseases. Smoking is one of the root causes. Therefore, he said, tobacco companies should not be permitted to sponsor events such as this.

"The economic consequences of smoking are also major," said Ms Begin and Mr Olivier. "Tobacco consumption gives rise to between $1 (billion) and $2 billion of direct hospital and physician costs annually. Moreover, when other costs such as lost wages, salaries, and fire damage are taken into account, total costs attributable to tobacco rise to more than $7 billion a year."

Tobacco also gives rise to large government revenues. The Canadian Tobacco Manufacturers' Council told **The Journal** that $2.4 billion was levied against the industry in taxes in 1982.

Back on the slopes, while competitors for the first day's 70-metre event were going through their paces, five anti-smoking activists carrying pin-on buttons and hats bearing the slogan, 'Expire, Eh? Coughin' Cup' moved through the crowd, handing out leaflets.

Only about 230 spectators were present, although the number more than doubled during the important 90-metre event on the next day. They showed little interest, however, in either the anti-smoking hats or buttons.

Mr Mahood said he was pleased with the Thunder Bay results. But many people who were handed the leaflets immediately threw them into the snow. And not one of the hats was visible on or near the slopes on either day, as far as I could see, although a reported 200 had been distributed.

In Toronto, shortly after the contests, Mr Mahood told **The Journal:** "We didn't expect to win any praise on the side of the hill. The event was referred to as the 'Expire, Eh? Cup' — that's what we were after and we know damn well that before the thing is over, there's going to be a lot of people calling it that. That was the objective, without question.

"But we were also doing something on a test basis and we wanted to find out what the response was." He said other demonstrations were being planned, but refused to say what shape they would take, or where they would be.

Perhaps the anti-smoking lobby's task would have been easier had they not been approaching people who were either directly involved with the games, or who had relatives taking part. Certainly, spectators were not enthusiastic about anyone who appeared to be interfering with the meet.

Sixteen-year-old Todd Gillman from Thunder Bay became the new Canadian junior 70-metre champion. Todd doesn't smoke, and doesn't intend to start.

He told **The Journal**: "The controversy didn't really affect me — but we could have done without it. But right now I feel terrific about winning, and all I want to think about is getting on with what I do."

His father, Bob Gillman, said: "I don't think children who might hero-worship someone like Todd will think smoking is glamorous just because a company like Macdonald is the sponsor.

"In fact, I don't really think the sponsor makes much difference. Todd is old enough to realize that you can't have a ski meet like this one without the kind of money and support that Macdonald provided. He personally has no intention of ever beginning to smoke and, quite honestly, I think they're doing a good enough job on that subject at the school level; they're successfully teaching kids the dangers of smoking.

"But if federal pressure forces sponsors like Macdonald to withdraw from events like this, a lot of people are going to be very disappointed. As a father, I don't see any problems, and as the father of a new Canadian champion, I don't see any problems."

Ontario coach Charlie Pastor, who has been training Todd for the last year, told **The Journal**: "If the federal government chooses to keep on using events like this as a way of approaching their anti-smoking campaigns, it's going to bother the officials far more than anyone else. Competitors are here to compete and I don't think they really care too much where the money comes from.

"We have to spend a lot to train on proper hills. We do fund raising all the year round, and people work hard — so sponsors are very important. And when sponsors like Macdonald do come along, the coaches, organizers, parents, and so on, really appreciate it. None of the kids on my team smoke, or would be allowed to, because sports people just don't. It's very simple. If they smoke, they'd be wasting their time and couldn't become sports people.

"None of the kids that I coach has the slightest interest in smoking, and I feel exactly the same way."

Greg Hilton, executive director of the CSA, was at Thunder Bay as an observer. "Right now all we want is to get on with the job of putting on competitions," he told **The Journal**. "I deliberately didn't talk to the skiers about this, and I was hoping anti-smoking groups would leave them alone.

"But they didn't on the weekend, and I'm most upset. These groups started phoning the athletes. I've no idea how many were actually approached, and I don't intend to ask. We can't cloud their minds with these kinds of issues, unless they have a concern, in which case they can come to us. But we are not going to sit down with them at this stage — to get into these kinds of questions . . . is a totally wrong thing.

"I'm not worried about the Horst Bulaus; they're experienced people who have already been through the grind. I'm talking about the nine- and 10-year-olds who were confronted over the weekend. There was no brand identification with Macdonald whatever — yet these anti-smoking groups asked the athletes to wear buttons and things.

"That's dirty pool."

Gillman: (above and at top of page) he "could have done without" the controversy

Photos by Danny Gasparik and Jon Newton

THE BACK PAGE

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The Journal

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Program helps addicted moms keep babies

By Tim Padmore

VANCOUVER — In August, the British Columbia Court of Appeal confirmed a lower court decision awarding custody of a Nishga Indian baby born addicted to methadone to the government.

The case of the baby, known only as DJ, was one in a small but continuing series of court battles in this province for custody of infants addicted to narcotics. (See box)

Children like DJ are not new to BC, but the determination by many addicted mothers to keep their babies is.

And, remarkably, many do and are successful parents, thanks largely to a program here involving three hospitals and two provincial ministries.

The program — described on The Back Page — aims to protect high-risk babies both before and after birth.

It has meant development of new technology and nursing skills. Among the advances:

- use of ultrasound to monitor fetal activity enabling doctors to adjust dosages of maintenance narcotics to protect infants from withdrawal or over-sedation;
- development of a new opium preparation to manage withdrawal after birth;
- establishing continuity of care for the baby from pregnancy to pre-school;
- encouraging parent participation in the hospital nursery to establish early bonding, teach parenting skills, and evaluate fitness for parenting; and,
- establishing legal precedents setting standards for returning once-addicted infants to their natural parents.

The success of the program is measured in part by the fact that only a handful of custody disputes go to court; close to half the children are able to stay with their natural parents.

More important, the program means that any infant conceived by an addicted woman has a good expectation of survival and the chance of a reasonably normal life.

Dr Sydney Segal, the Vancouver pediatrician who developed the program explains: "I don't support the idea of addicts producing babies, but if they're going to produce babies, then we should do as much as we can for the babies, and provide as much support as we can for the mothers. Sometimes we get kicked in the teeth, but usually we do pretty well."

Addicted babies: new technology and nursing skills are helping (See The Back Page)

DJ's story

DJ, a narcotic addicted newborn, was at first left in the care of her mother, with close supervision by a social worker and community health nurse. But, in May 1982, the baby was taken into custody by the authorities.

In establishing the earlier, close supervision for DJ, British Columbia Supreme Court Justice Patricia Proudfoot ruled that a drug-addicted baby is born abused. She said the abuse occurred during the gestation period and that the baby is now susceptible to myriad life-threatening health problems and, therefore, she is "a child in need of protection" under the Family and Child Service Act.

Testimony came from a public health nurse that the mother's common-law husband had been abusive during a visit and that the parents objected to her consulting with pediatrician Sydney Segal. This contributed to a later court decision giving custody to the province, which placed DJ in a foster home.

The case went all the way to the Court of Appeal when the mother's brother applied for custody, offering the child a home with his family, where she could be brought up as a member of the Nishga Indian band.

However, last August, Justice A.B. Macfarlane supported a lower court rejection of the application.

Fentanyl: a powerful new option for California heroin addicts

By Jon Newton

MARTINEZ, Cal — Fentanyl citrate, a synthetic opiate analogue, could be on its way to becoming a rival for heroin as one of the most potent street narcotics, says Martin LaBarbera, coordinator of substance abuse for detention facilities in Contra Costa County here.

His view is shared by David Smith, MD, medical director of San Francisco's Haight-Ashbury Free Medical Clinic.

Abuse has been reported among members of the medical profession (see page MD1), but Mr LaBarbera and Dr Smith say fentanyl is now being used outside of the clinical and pharmaceutical contexts.

There are several reasons:

- Fentanyl (Sublimaze) is up to 2,000 times stronger than heroin.
- $200 buys ingredients for a 24-month supply which could translate into about $2 million on the illicit market.
- The same $200 worth of precursors can be transformed in about a week in a relatively simple laboratory sequence.
- Detection with current analysis techniques is virtually impossible.
- It's synthetic, meaning no opium base is needed, so there is no importation problem for drug criminals.
- Because fentanyl can be produced domestically, law enforcement agencies could not rely on border seizures to lead them to clandestine laboratories.

Moreover, says Mr LaBarbera: "As narcotic enforcement agencies become more adept at limiting the amount of opium-based narcotics that can be imported into this country (the United States), and as quantities increase, synthetics like fentanyl will become even more widely abused."

One reason the narcotic — used as an analgesic in clinical settings — has remained relatively unknown, except in Southern California, is that while it is far stronger than heroin, the initial "rush" is not as intense, he explains.

He also believes fentanyl is not being made illegally in quantities sufficiently large to make it more generally available on the streets.

The drug's potency has led some addicts to call it China White, a nick-name usually reserved for all but ultra-pure heroin.

Says Dr Smith: "We've seen addiction in doctors and nurses, and fentanyl synthesized in clandestine labs is showing up as China White. This implies to addicts that the drug is heroin, when it's fentanyl.

"In fact, we're now calling it a drug of deception, because it's sold as one narcotic when it's actually another."

Because less goes further, it can be cut heavily, thus increasing its dollar value but also increasing the risk of overdose to addicts. Furthermore, it is soluble in water and doesn't have to be "cooked" over a flame prior to injection, unlike heroin.

Mr LaBarbera says abuse seems to be confined, for the moment, to counties in the San Francisco Bay area. However, fentanyl's characteristics suggest it could travel, as did LSD in the 60s, to other areas of the US and even beyond, he says.

Dr Smith agrees. "We've seen roughly about 50 health professionals and 100 street addicts scattered over a period of about three years," he says.

(See — Addicts — page 2)

INSIDE

Special section

Alcohol, Drugs, and the Doctor

— A symposium of opinion —

Pages MD1 - MD4

NEWS

Briefly . . .

Gerbil jobs cancelled

WARKWORTH, Ont —Gerbils used at the medium security prison here to sniff out illegal drugs being smuggled in have been given their walking papers. Technical difficulties with equipment used to monitor the animals, and with the apparatus activated by the gerbils when they detected anxiety in people entering or leaving the building, were cited as reasons for the cancellation of the $60,000 program for Canadian prisons. (The Journal, March 1983)

Paying more for less

LONDON — Beer drinkers here may be paying more for their pint and getting a weaker brew. *The 1984 Good Beer Guide*, which ranks pubs throughout Britain, took pub owners to task for overcharging and for declining service and cleanliness. And some brewers, the guide said, "are also sneaking through disguised price increases by reducing the strength of beer they sell and, therefore, the duty they have to pay on it."

Snuff warnings

WASHINGTON — The Health Research Group, led by United States consumer advocate Ralph Nader, has called for cancer warnings on advertisements for snuff and chewing tobacco. The group says an estimated 22 million people in the US, including "increasing numbers of young males," use smokeless tobacco products.

Time to quit

OTTAWA — An 83-year-old woman here has vowed to give up smoking following a recent court case, reports the *Toronto Star*. The woman, who had never been in trouble with the law before, was given an absolute discharge after admitting to stealing 12 cartons of cigarettes worth $170. "I won't smoke any more. Cross my heart," she told the judge.

Pack-years equal risk

PHILADELPHIA — People can't say, 'Now I'm 40, I'll stop smoking,' and reduce the risk of coronary artery disease (CAD), say researchers here. Dr William Weintraub, clinical assistant professor of medicine at the University of Pennsylvania, says in *Medical World News* (Jan 9) that "pack-years" (the mean number of cigarette packs smoked per day multiplied by the number of years a person has been smoking) are important in assessing the continuing likelihood of CAD. "The basic underlying disease is not going to disappear," he says. CAD risk increases with the number of pack-years and this should be taken "very seriously from a public health standpoint."

Single cigs for kids

LONDON — Three surveys conducted by the British anti-smoking group, ASH (Action on Smoking and Health), show that 80% of tobacco stores surveyed sold cigarettes to children under the age of 16, says *Medical News* (Jan 12). And the fact some shops sold single cigarettes to youngsters for about 17¢ each meant children "as young as seven, who would not otherwise be able to afford it," became regular smokers.

Canadian skiers will be allowed to refuse tobacco trophies

TORONTO — A national newspaper report that the Canadian Ski Association (CSA) will ban skiers who refuse to accept awards sponsored by tobacco companies is "completely untrue," says Greg Hilton, CSA executive director.

A report in the *Globe and Mail* on March 7 stated: "The Canadian Ski Association is drafting a regulation that would prohibit future winners of national championships from refusing to accept awards provided by sponsors of the events."

Mr Hilton told **The Journal**: "We want to know in advance if any of the participants are going to raise objections, but we're certainly not going to sanction anybody, or say, 'You can't compete if you don't accept.' "

The RJR-Macdonald tobacco company and CSA have been under heavy criticism from anti-smoking groups and from the ministers of health and amateur sport (**The Journal**, March).

In February, skiing superstars Steve Podborski and Jim Read both refused to accept trophies paid for by Macdonald as part of its $1.7 million sponsorship deal with the CSA.

But Mr Hilton told **The Journal** he had no difficulty with this. "As far as Steve is concerned," he said, "he made us aware of his feelings all along, and it was agreed by all to accept his wishes. He was man enough to let us know how he felt, and we had no problems with that.

"I think, though, that we should have some sort of agreement prior to going into the season. If skiers decide not to accept trophies, fine. But we want them to let someone know ahead of time, so there are no surprises on the day.

"We're in the business of providing an environment for these kids to excel in the field of skiing, and we're not about to restrict them because of a particular sponsor."

Meanwhile, the oft-arranged but never-held meeting among the CSA, Macdonald, and the ministries of health and amateur sport to discuss the issue had been scheduled for March 21, but was again cancelled.

Health Minister Monique Begin and Fitness and Amateur Sport Minister Jacques Olivier eventually hope to persuade Macdonald and the CSA that their collaboration is unacceptable.

The ski group and Macdonald, however, told **The Journal** they intend to live up to their contracts and have no plans to cancel their agreement unless "forced" to do so by Ms Begin and Mr Olivier.

Podborski: an environment

DC cracks down on drug-using transit workers

WASHINGTON — The District of Columbia Metro (transit system) fired 86 employees last year because they showed positive drug or alcohol results in tests following accidents or other incidents. They included bus and subway drivers.

Another 10 employees were fired after refusing to take blood or urine tests which Shirley Delibero, director of bus operations, ordered for certain incidents or accidents.

Ms Delibero, appointed at the end of 1982, decided on a mandatory testing policy because, she said, too many accidents or incidents involving Metro employees could not be satisfactorily explained. These included employees involved in fights or who flagrantly disregarded standard operating procedures.

Local union officials opposed the mandatory testing, but lost their case in court. Metro officials point out there is an employee assistance program, but if employees wait until they are caught drinking or using drugs on the job, it is too late.

Uof T gets AIDS research funds

TORONTO — Most of the $500,000 set aside last summer by Ontario Health Minister Keith Norton as an AIDS (Acquired Immune Deficiency Syndrome) investigation fund has been awarded to a University of Toronto research team (**The Journal**, Dec 1983).

Headed by Colin Soskolne, PhD, and Randy Coates, MD, the team will receive $91,119 in start-up funds before the end of the year, and a further $352,652 in operating costs in 1984/85.

Research will focus on 420 homosexual or bisexual men who will undergo a series of medical tests every three months for up to three years. Those who develop AIDS or ARC (AIDS-related complex) will be compared to those who remain healthy, in a bid to determine factors which increase the risk of acquiring either condition.

Volunteers will not be accepted for the program. The study group will comprise patients referred from family physicians and via a "variety of means," says the ministry of health.

So far there have been 67 cases of AIDS reported in Canada, 23 of them in Ontario. Twelve of the Ontario patients have died.

Late last year four intravenous drug abusers had been identified among Canada's AIDS cases, one of whom did not belong to any other risk group.

BC reconsidering methadone maintenance

VANCOUVER — A decision is expected soon on whether British Columbia will allow graduates of a new "methadone stabilization" program to go on indefinite maintenance.

For the past five years, BC's methadone maintenance program has been suffering under a "no new admissions" policy. Where once there were more than 300 clients, there are now only about 50.

But a little more than a year ago, the health ministry began a program of methadone stabilization. It differs from the maintenance program in that there is a ceiling on the amount of methadone that can be prescribed (60 mg a day); there is a provision for six month reviews; and, most important, there is a ceiling on the total length of time an addict can be in the program — 18 months.

William Young, MD, who directs both programs, hopes that sometime this spring the BC cabinet will accept his recommendation to lift, or at least extend, the ceiling on treatment time.

But extension is not appropriate for everyone, he told **The Journal**.

"I hope there will be about a third who would require withdrawal from methadone during the treatment period, about a third that we would lose (from treatment), and about a third we would be successful in stabilizing . . . in terms of lifestyle, and (who) could then be offered methadone maintenance."

Dr Young said stabilization is an important preliminary to maintenance.

"You shouldn't make a decision about methadone maintenance until you know the patient better," he added.

Addicts not afraid

(from page 1)

"Right now its presence is determined by supply and availability, but we're starting to get calls from the east coast and other parts of the US."

The fact that at least 18 overdose deaths have been attributed to fentanyl does not seem to deter addicts. "It's well known to users in this area," Mr LaBarbera said, "and it's certainly most acceptable to them. They're not afraid of it."

Current mass urinalysis techniques are not sufficiently sensitive to detect traces of the drug in samples, they said.

In a pilot study * of fentanyl as an up-and-coming drug of abuse, Mr LaBarbera and co-worker Toni Wolfe remark: "From July to December 1980, the methadone programs in northern California's Contra Costa County experienced a notable decrease in positive urinalysis statistics. As well, 15 applicants to the program were rejected due to the inability to verify addiction through urinalysis testing.

"This phenomenon coincided with the initial reports of fentanyl availability in southern California and indicated the likelihood that fentanyl had spread more rapidly than anticipated. A survey of Contra Costa County's Pittsburg Methadone Program clients in February 1981, verified that 80% of those interviewed had used fentanyl, and some as early as June 1980."

*Characteristics, Attitudes and Implications of Fentanyl Use Based on Reports from Self-Identified Fentanyl Users — *Journal of Psychoactive Drugs*, Vol 15(4), Oct-Dec 1983.

Firebreathing: a dangerous adventure

LUBBOCK, Texas — When a 14-year-old boy here went to his doctor complaining about severe stomach pains in the morning, pediatrician Wallace Marsh suspected an ulcer.

Examinations at first failed to reveal the cause of the problem. But then the boy admitted he had been experimenting with firebreathing by spraying butane lighter fluid into his mouth and then lighting it to mimic a television act.

"The other kids at school were calling him 'Puff the Magic Dragon,' " Dr Marsh told The Journal. "He got lots of attention, and I know of at least two other kids who imitated him."

Dr Marsh said he and his colleagues were expecting a rash of copy-cat cases, but, fortunately, these failed to materialize.

The boy later said he had been performing his do-it-yourself firebreathing act for about a month before experiencing the stomach pains. Swallowed butane was causing the discomfort, and Dr Marsh now believes: "Firebreathing must be added to the growing list of potentially dangerous adventures undertaken by today's youth."

The boy is fully recovered and has shown no further tendency to imitate firebreathers, said Dr Marsh.

NEWS

Loss of profits expected to provoke opposition

Pharmacists may be asked to stop cig sales

By Maureen Brosnahan

WINNIPEG — A national program to convince pharmacies to stop selling tobacco products is being developed by the federal government and the Canadian Pharmaceutical Association (CPhA).

It will affect about 17,000 pharmacists in the country's 6,000 pharmacies and will probably be launched in May at the annual meeting of the CPhA in Vancouver.

However, opposition is expected from some pharmacies since about 25% of all tobacco products sold in Canada are sold through drug stores, said Leroy Fevang, CPhA executive director. Many pharmacies use tobacco sales as a way to attract regular customers, he said. "There doesn't appear to be another product that has the same draw."

As well, one of Canada's largest drug store chains, Shoppers Drug Mart, is owned by Imasco, which in turn owns Imperial Tobacco.

David Bray, PhD, head of the federal Bureau of Tobacco Control, who approached the CPhA with the idea last fall, said the program is "still very much in the formative stages."

Margaret Thomson, a member of the Manitoba Interagency Council on Smoking and Health, said she is pleased with the proposal.

"One thing it would cut out is the advertising in the drug store flyers," she said. "I would see that as a step forward."

Mr Fevang said the details are being worked out and that he and government officials have met with representatives from the country's two largest drug store chains — Shoppers Drug Mart and Boots Drug Stores.

Tobacco: a major draw for drug store shoppers

Jim Mintz, director of marketing and communications for the health promotions branch of Health and Welfare Canada, said representatives from both chains reacted favorably to the idea, which also involves helping to promote the federal government's Generation of Non-Smokers program (**The Journal**, May 1982). He said he expects the companies to respond formally within a month.

"All things considered, I think we got as favorable a response as one could expect," he said. "We weren't too hopeful with Shoppers Drug Mart for obvious reasons, but they weren't negative . . . that in itself was a major victory."

Mr Mintz said while they are gearing their first efforts to the large chains, he expects the main support to come from small independent drug stores.

Mr Fevang said he supports the program because it promotes the idea of pharmacists as health care professionals. But, at the same time, many pharmacists rely on tobacco sales to bring in regular customers.

He said the program could involve a system of rewards or public recognition for pharmacists who choose not to sell the products. But, he added, the CPhA is treading carefully to avoid problems among the membership.

"We don't want to appear to be giving the public the impression that one pharmacist is better than another because he doesn't sell tobacco products."

Mr Mintz said participating pharmacists will also be encouraged to display posters and distribute pamphlets promoting the Generation of Non-Smokers program. But, he doesn't expect all pharmacists to stop selling tobacco.

"Getting pharmacists who are businessmen not to sell cigarettes is not going to be easy."

Such a program has to be voluntary and built on cooperation. "I don't think we want to get into blackballing or blackmailing."

Jack Davis, executive director of the Manitoba Association of Professional Pharmacists, expects the program will be endorsed by pharmacists despite the opposition. Some pharmacies in Manitoba have already stopped selling tobacco, and others are refusing to advertise it in flyers.

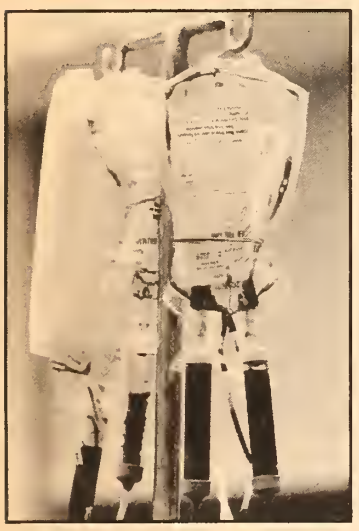
"It's the old business that someone is going to sell it anyway," he said. "The pressure will be on . . . the suggestion has been made before."

Smokers should butt out a day before giving blood

CARMEL, Cal — Smokers should avoid lighting up for 24 hours before giving blood, says an Omaha research team reporting on the high levels of carbon monoxide in random units of donated blood.

The study, conducted at the Creighton University School of Medicine, Omaha, Nebraska, was reported here at the annual meeting of the western section of the American Federation for Clinical Research.

Wilbert Aronow, MD, assistant professor of medicine, explained that carbon monoxide can impair heart and lung function in patients with heart or lung disease, and that carbon monoxide levels in certain samples of banked blood have been high enough to cause damage.



He also said earlier studies have shown that the level of carboxyhemoglobin (COHb — carbon monoxide in the blood) for blood donors who were smokers exceeded 5% in most cases.

A COHb level of 2% can be dangerous in some patients.

To test the prevalence of high COHb levels in a chance sample, the Omaha team studied 101 randomly selected blood donors between October 1982 and March 1983.

Dr Aronow said 36 units had COHb levels exceeding 2% and almost 11% exceeded 5%, with one unit having a COHb level of 12%.

Because multiple infusions of blood with these high COHb levels could be dangerous to patients with severe heart or lung diseases, the study recommends that banked blood be labelled with COHb levels.

"An effort to educate donors to avoid smoking for 24 hours before donating blood would also help alleviate the problem," Dr Aronow said.

Public FAS warning offends feminists

By Lynn Payer

NEW YORK CITY — Bars, restaurants, and liquor stores here now must display prominently the sign: "Warning: Drinking alcoholic beverages during pregnancy can cause birth defects."

Failure to do so can result in a $100 fine. The measure was passed by city council following efforts by the local affiliate of the United States National Council on Alcoholism (NCA).

The measure was opposed by some feminists, including the local chapter of the National Organization for Women (NOW).

Barbara Rochman, president of the New York City NOW said: "The effects of alcohol abuse are so widespread, with drunk driving killing so many people and alcohol causing so much violence and disease, that singling out women seems to us a scare tactic that may cause harassment of some women.

"We are in favor of educating women to the dangers of drinking during pregnancy in an appropriate manner, but posting a warning directed only at women in a bar is a scare tactic."

Allan Luks, executive director of the local affiliate of the NCA, said the narrow focus was chosen following the results of numerous Gallup surveys. The states of Kansas, North Carolina, and Maine are considering similar legislation, as is the city of Buffalo, NY.

A similar measure was defeated in San Francisco on the grounds that such legislation was a state responsibility. An attempt is being made to assess the effectiveness of the warning by measuring public awareness of the matter both before and after the signs were posted, Mr Luks said.

Coming up in

The Journal

- **Parks and recreation: clearing out alcohol and other drug problems**
- **Reports from the PRIDE conference for Parents and Professionals, Atlanta, Georgia**

Liquor store marketing — a temperance ploy

By Wayne Howell

According to recent reports, both Quebec and Ontario are considering fundamental changes in the marketing of alcoholic beverages (see page 4).

The Quebec government proposes to sell its government-owned liquor stores to employees who would then operate the stores in a 'free-enterprise' fashion. In other words, the province is flirting with American-style decadence such as I recently encountered in a privately-owned and operated liquor store in the State of New York. Not only was I subjected to friendly conversation, but after the woman behind the counter ascertained that my purchase was a gift, she insisted upon gift-wrapping it for free and threw in a decorative bow for good measure.

Needless to say, such behavior would not be tolerated in a Canadian provincial liquor store. When I worked in a provincial government liquor store we had standards, and we knew how to treat our customers: like dirt.

In those pre-metric days, a 36-ounce bottle of *Retsina* was one of our better wine bargains and so, not uncommonly, it was chosen by many of our one-day-a-year, non-Greek, wine-drinkers as just the thing to have with Christmas dinner. Did we tell these people that Retsina was not a typical white wine, that its formula was devised in ancient Hellenic times when there were no such things as corks and wine had to be preserved by additives?

Did we tell these people it tasted like turpentine? No way. The old provincial employees would snicker and chuckle gleefully whenever another mark took the low-priced bait. Some people who got burned on Retsina probably never tried a bottle of wine again.

We were a force for temperance, without a doubt. And we took our responsibilities seriously: we were prideful of the fact that we knew next to nothing about the products we were selling, the better able to ensure that the customer would be unlikely to get what he wanted.

(We never, of course, let the customer actually see what he was going to get: first we took his name and address, then we took his money, and then we presented him with his purchase as a *fait accompli*. Take it or leave it buddy.)

Ah, we were tough: the idea of selling the stuff with bows and ribbons would have had us rolling in the aisles. Tough, but efficient. We kept the cheap sherry right under the counter, the better able to serve our wino population. The idea of making friendly conversation with those chaps would have had us rolling in the aisles, too. We were the men of the provincial liquor board — we didn't care about any of our customers, healthy or sick. We had tradition and we had standards. If Quebec thinks those traditions and those standards can be maintained under a "free-enterprise" system, it had better think again.

Ironically, at the very time when Quebec is flirting with American-style decadence, Ontario is flirting with Quebec-style decadence. Prescott-Russell Member of Provincial Parliament Don Boudria planned to introduce a private member's bill in the Ontario legislature that would allow the sale of Ontario wine and beer in small grocery stores.

This kind of thing has been going on in Quebec for years (**The Journal**, March 1984, April 1978).

It was going on during the six years I lived there, and, although it is a fact that no Quebec corner store owner ever offered to wrap a purchase of mine with a bow and a ribbon, the owners habitually engaged me in friendly conversation. And I have the uncomfortable feeling that if I had asked for gift-wrap it would have been provided. In short, proper standards were just not being maintained.

Does Ontario want Mr Hall, the corner store owner of Lottario fame, to be selling beer and wine as well as lottery tickets?

I ask you.

NEWS

Survey records lowest daily marijuana use

US teen drug use is still dropping

By Harvey McConnell

WASHINGTON — Drug use among United States high school seniors is, in the main, continuing to decline and is not being replaced by increased drinking.

Marijuana, barbiturate, methaqualone, and LSD use declined; heroin, other opiates, and cocaine use remained unchanged; and PCP (phencyclidine) use showed a small, but not statistically significant, increase in the 1983 national high school senior survey. It was conducted for the US National Institute on Drug Abuse (NIDA).

The 1983 survey, carried out annually since 1975 by Lloyd Johnston, PhD, and colleagues at the University of Michigan, involved 16,300 seniors from 130 public and private schools across the US.

A significant finding is that daily marijuana use among high school seniors fell for the fifth straight year and today, at 5.5%, is lower than the level (6%) found when the survey first began. The highest daily-use level (10.7%) was recorded in 1978.

The proportion of seniors who used marijuana during the year prior to the survey (42%) continues to decline from the highest level (51%) reported in 1979.

At the same time, the report says, "there is no evidence that the currently observed drop in marijuana use is leading to a concomitant increase in alcohol use."

Daily alcohol use (5.5%) has dropped slightly again from the 6.9% reported in 1979. The proportion of seniors who have had five or more drinks in the two-week period before the survey remains unchanged at 41%.

Overall, 63% of seniors admitted trying an illicit drug, 40% had tried an illicit drug other than marijuana, and 47% had used an illicit drug in the year preceding the survey.

Dr Johnston said: "The 1960s and 1970s marked perhaps the most sizeable and widespread epidemic of illicit drug use ever experienced by any country. The use of marijuana, various hallucinogens, cocaine, and other drugs spread at an unprecedented rate, particularly among our youth.

"In the 1980s, by way of contrast, we have experienced a levelling and the beginning of a decline in youthful drug involvement, and in the case of some specific drugs, a quite substantial decline."

The findings, while encouraging, must not obscure the fact that most young people experiment with illicit drugs by the time they leave high school, and a substantial number become seriously involved, he said.

"I know of no other developed country in the world where such a large proportion of youth become involved with drugs," Dr Johnston said.

Similar views were expressed by William Pollin, MD, NIDA director; "There still remain large subgroups in the general population whose drug-use patterns are becoming heavier, more compulsive, and more damaging." Data from the Drug Abuse Warning Network (DAWN) show a steady increase in emergency room mentions for heroin and cocaine since 1980 (**The Journal**, March).

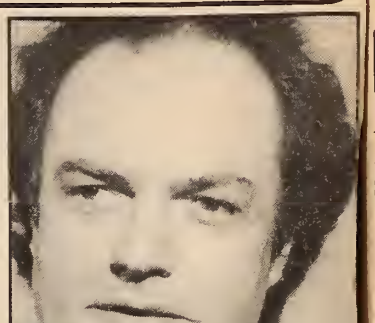
"The drug abuse problem in this country continues at a tragic level, especially for our young people," Dr Pollin said.

Dr Johnston and his colleagues found that, overall, US youngsters have developed a more cautious attitude about regular marijuana use, due primarily to concern about psychological and physiological effects. Peer attitudes are also hardening against daily use.

In contrast, in 1983, 63% of high school seniors believed regular marijuana users ran a risk of harming themselves physically or in other ways, whereas in 1978, only 35% of seniors held this view.

In addition, 83% of the 1983 seniors compared with 68% in 1978, said they personally disapproved of regular marijuana use, and 61% disapproved of even occasional use.

Nor is the change in attitude attributable to decline in availability: 86% of the seniors said they could get marijuana if they chose to do so.



Johnston: attitudes hardening

Pollin: level still tragic

In the category of drugs used by seniors in the year before they were questioned, the survey found: marijuana 42%, heroin 4%, amyl- and butyl-nitrite 4%, hallucinogens 7%, LSD 7%, PCP 3%, cocaine 11%, heroin 1%, other opiates 5%, stimulants 25%, sedatives 8%, barbiturates 5%, methaqualone 5%, tranquillizers 7%, and alcohol 87%.

As for cigarette smoking, 30% said they had used cigarettes in the past month, and 21.2% said they were daily smokers.

RESEARCH UPDATE

Drug users' infants need long-term care

Infants born to mothers who are substance abusers tend to have declining mental scores and a decline in appropriate attachment behavior in the first two years of life, suggests a California study. Researchers from the department of pediatrics, Los Angeles County-University of Southern California Medical Center, followed a group of 24 physically and neurologically normal infants in a special pediatric clinic. The clinic was designed for the care of children born to mothers with heroin, PCP, or poly-drug abuse problems. Infant development and infant-mother attachment were measured (with the Bayley Scales of Infant Development and a modification of the Ainsworth-Bell Infant-Mother Attachment Scale respectively) at one and two years. Mental scores for the infants dropped from a mean of 95.5 at one year to 87.3 at two years, with seven of the infants (five male) having suspect (below normal) scores at that time. Evaluation of infant-mother attachment showed 17% of the infants had abnormal behavior scores at one year and 29% at two years. The researchers said male infants appear to be more vulnerable to this decline and that "health providers must recognize that these high-risk families need long-term surveillance and may benefit from educational and counselling support."

Clinical Research, February 1984, v.32:92A

'Leaky gut' clue to gastrointestinal ills

British researchers have pointed to the "leaky gut" of alcoholics as a possible reason for their greater susceptibility to various gastrointestinal disorders. Ingvar Bjarnason, Kevin Ward, and Timothy Peters of the division of clinical cell biology, Medical Research Council Clinical Research Centre, Harrow, Middlesex, tested the intestinal permeability of 36 non-intoxicated alcoholics who did not have overt evidence of malabsorption or malnutrition, and 34 healthy volunteers as controls. This was done by using a test solution including edetic acid and testing urine samples collected over the next 24 hours. The study found that 26 patients who had been drinking up to two days before admission to hospital excreted significantly more of the test dose. Patients who had stopped drinking up to two weeks before also excreted more of the test dose than the control group. This abnormality was found to be independent of gastric inflammation and the patients' nutritional state. "It seems clear that raised permeability could result in the absorption of toxic non-absorbable compounds of a molecular weight less than 5,000, which could possibly accelerate the extraintestinal damage that is so common in alcoholics," concluded the researchers.

The Lancet, Jan 28, 1984, No.8370:179-182

Low FAS risk in first trimester bingeing?

Women who binge drink two or three times during the first trimester of pregnancy do not appear to be at increased risk of giving birth to children with symptoms of fetal alcohol syndrome (FAS), in contrast to those who drink heavily throughout pregnancy. This conclusion came from three researchers at the department of pediatrics, University of California, San Diego. They used data from the California Teratogen Registry to compare the children of women who did not drink, women who binged on one to three occasions during the first trimester, and women who drank heavily throughout the pregnancy. Their babies' average birth length, weight, and head circumference were measured, as were incidences of prematurity or spontaneous abortions. These parameters were not significantly different in the groups of 58 children born to women who had binged, or the 98 children born to women who drank less than one ounce of absolute alcohol a day. And, no baby born in either group had any features of FAS. Of the seven heavy drinking women, the study found one had a first trimester spontaneous abortion, two gave birth to children with FAS, and the average weight for full-term babies was significantly less than the other two groups. The researchers said while the data indicate women who drink to the point of feeling drunk on one to three occasions in the first trimester of pregnancy are not at greater risk of having a baby with any of the prenatal effects of alcohol, intellectual performance in the infants had yet to be evaluated.

Clinical Research, February 1984, v.32:114A

Pat Rich

Brain cell/alcoholism link probed

SAN FRANCISCO — Research scientists here may be one step closer to discovering if there is a genetic link to alcoholism, following studies on isolated brain cells.

But the team, led by Michael Charness, MD, assistant professor of neurology, the University of California at San Francisco (UCSF), emphasize it could be many years before definitive results are produced.

"I'm young, and I'm not despairing," Dr Charness told **The Journal**, "but if I were 65 I'd say it's going to be someone else's discovery, because I think comparatively little is understood right now about how alcohol works."

Other team members are Adrienne Gordon, PhD, associate professor of pharmacology in neurology, UCSF, and Ivan Diamond, MD, PhD, UCSF professor of neurology, pediatrics, and pharmacology, and director of San Francisco's Ernest Gallo Clinic and Research Center.

The researchers believe exposure of isolated brain cells to alcohol alters membrane function in a way that may help explain intoxication, tolerance, and withdrawal. "Perhaps there is an abnormality in the cell membrane function of people predisposed to alcoholism," they say.

"If we develop tests to show that the adaptive responses of alcoholics are different, we could identify people at risk."

Dr Charness and colleagues examined the effect of alcohol in various concentrations on the ability of cell membrane receptors to bind with methionine enkaphaline, an opiate that is produced naturally in the brain and relays information between nerve cells.

If it can't bind to the appropriate receptor on the cell membrane, it cannot deliver its information.

"The hope of any of these studies is to be able to understand at a molecular level what alcohol is doing to cells to produce its effects, and how the cells are adapting to them," Dr Charness told **The Journal**.

"We hope, as a long-range goal, to be able to characterize some of the molecular events that underlie alcohol's effects on cells, as well as their adaption to ethanol. And by what we understand from these studies, we can begin to search for differences in the biochemical responsiveness, or constituency, in cells of people at risk of alcoholism, or who are alcoholics.

"There is more than a suspicion, with some fairly good evidence to support it, that at least a component of alcoholism has a genetic basis. If that's so, it has to be expressed in some molecular aberration — there has to be some difference the genetic code is passing on in the way of, perhaps, a different molecule, or a different enzyme."

The researchers say this speculation is spurred by the fact that although alcohol initially inhibits opiate binding, nerve cells adapt by increasing their opiate receptors.

Further research is needed to determine the exact mechanics of the process, conclude the team, but "the changes in these isolated living cells may parallel the clinical phenomena of intoxication, tolerance, and withdrawal."

Ont 'grocery wine' unlikely but Quebec forges ahead

TORONTO — Ontario is unlikely to follow Quebec in allowing the sale of wine and beer in small grocery stores (**The Journal**, March), says a spokeswoman for Consumer and Commercial Relations Minister Robert Elgie.

A private member's bill proposing such a move was scheduled to be presented in the Ontario legislature by opposition member Don Boudria last month.

However, Joanne Delaurentis, executive assistant to Mr Elgie, said the government is "not, at this time, prepared to go that route."

Although an interministerial committee is investigating the question, Mr Elgie "certainly didn't want to leave anyone with the impression there was any imminent decision being made."

Quebec, however, may follow the lead of several states in the United States and move to privately-owned liquor stores.

The Quebec Liquor Corporation has announced it hopes to sell all of its 360 stores to employees.

Under the proposed system, the prices would still be set by the liquor corporation, which would also continue its other operations such as bulk imports and bottling of alcoholic beverages.

Details of the Quebec plan must be worked out and approved by the employees involved.

Ms Delaurentis said problems with the suggestion to permit sale of beer and wine in Ontario grocery stores include: deciding which outlets should be included; whether Ontario wine only should be sold, considering international trade agreements; and policing sales to ensure minors are not purchasing wine.

GILBERT

will return next month

Last licit methaqualone manufacture in US ends

By Jon Newton

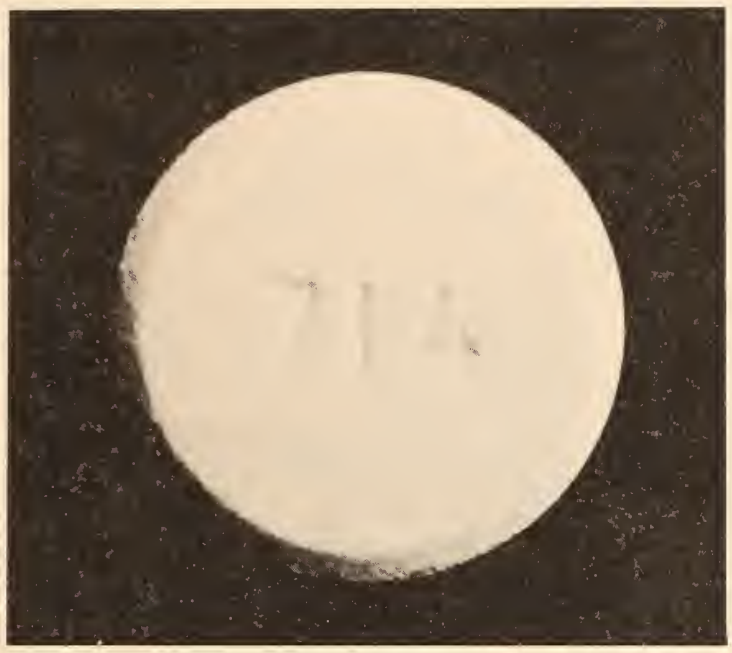
SELLERSVILLE, PA — Quaaludes, the last legal form of methaqualone in the United States, have been withdrawn permanently from the market, chiefly because of "unjustified negative publicity," say the makers here.

"Quaaludes were good," a spokeswoman for Lemmon Company told **The Journal**. "The problem was abuse. We will not be manufacturing any further methaqualone-type products."

Lemmon halted distribution in January this year. Left-over stocks will be destroyed, said the spokeswoman, leaving only inventories which have already been delivered to authorized wholesalers. There will be no re-stocking when supplies are exhausted.

A company statement says: "Extensive clinical studies and years of clinical experience have established methaqualone as a safe and effective hypnotic when used according to approved labelling.

"However, the widespread availability of illegally-manufactured methaqualone tablets, and the illegal actions of so-called 'stress clinics,' (usually financed by non-professionals who hire physicians to work for them) has led to the abuse of methaqualone."



Imitation: an illegally manufactured Quaalude look-alike

"Ludes," as the tablets were dubbed by street users, gained widespread popularity because of their alleged aphrodisiac qualities and the euphoric "high" abusers claimed they offered. Methaqualone was also nick-named "pillow" and "love drug."

Abuse reached epidemic proportions in Japan, Germany, and England in the 1960s; the product was sold in the United Kingdom as Mandrax. Methaqualone, combined with weak heroin solutions, was also popular with US addicts.

The drug is currently made in Canada by Rougier Inc, Montreal, under the brand name, Rouqualone, and there are no immediate plans to discontinue production, spokesman Jean-Paul Lefebvre told **The Journal**.

"Of course, if the health protection branch (of Health and Welfare Canada) decides to stop sales, that's a different ball-game — we'd have no choice. But there is no reason to discontinue it over the short term, and, in any event, it's a very marginal product as far as we are concerned," he said.

Health protection spokeswoman Jean Sattar said: "No decision has yet been made about the continued sale of methaqualone in this country."

Meanwhile, the drug is still widely available in Europe, and there is fear of an increase in poorly-prepared counterfeit tablets pressed in South America from the European base and already widely-available in the US.

Furthermore, two similar preparations are likely to fill at least part of the vacuum left by the disappearance of Quaaludes, says Michael Jacobs, PhD, co-author of the Ontario Addiction Research Foundation's book *Drugs and Drug Abuse*.

"I'd say Doriden (glutethimide) and Placidyl (ethchlorvynol) will probably start turning up," Dr Jacobs told **The Journal**. "Placidyl seemed to be going the way of the Do-Do, but reports are appearing in DAWN (the US Drug Abuse Warning Network) data, and Doriden is popular on the west coast (of the US and Canada)."

High doses of Doriden produce a barbiturate-like euphoria and can cause serious respiratory problems and death from cardiovascular collapse. Placidyl, prescribed as both a day-time sedative and a sleeping pill, can produce potentially fatal respiratory failure.

Baseball players, not fans, are the concern

Players, owners cooperate on drug policy

NEW YORK — As the 1984 baseball season begins this spring in North America, a joint committee of major league players and owners is expected to present a new policy on the sport's much-publicized drug problem.

If the policy is adopted, baseball will be one of the last big-business sports in North America to toughen its official stance on drug use by players.

Under the policy, players with drug problems will be encouraged to come forward for treatment. But there is a catch.

While clubs will try to help ballplayers to overcome their addictions, says Lee MacPhail, head of a management committee for the Player Relations Committee, owners will have the right to discipline players through "salary abatement." Furthermore, players will be responsible for any "legal problems" that may arise.

Mr MacPhail, who represents baseball owners on the joint committee, told **The Journal**: "If a player is impaired on the field because of his drug problem, a team management has to protect itself economically." But salary abatement would be recommended only "after a period of time," he said.

Nonetheless, the policy will probably focus more on treatment and education, with less emphasis on surveillance than other professional sports that have recently adopted drug policies.

Belanger: former Orioles shortstop (top) now looking to aid drug-using players

The joint committee has been helped in this respect by advice from Donald J. Ottenberg, MD, an expert on drug and alcohol treatment who has been retained by the committee to help with policy framing. Dr Ottenberg is retired director of Eagleville Hospital and Rehabilitation Center, King of Prussia, Pennsylvania.

"Dr Ottenberg is helping us to understand chemical addiction, and we're educating him about the baseball world," said Mark Belanger, former Baltimore Orioles shortstop and special assistant to the executive director of the Major League Baseball Players Association.

Mr Belanger, representing the players' union on the committee, said: "Our first concern is for the individual. If a player has a drug problem, we want him to get the best of all possible help.

"We're not as concerned about the fans as we are about the players. We feel players have their rights, as owners do. To us, the major league baseball player is a human being first, a sports celebrity second. We want to help, not punish, our players."

Owners, he said, have to be concerned with fans and the image of the sport, but the common ground between player and owner representatives on the committee is, "we know there are people out there who need help, and we want to be able to offer that help and do what's best for the sport."

Mr Belanger said the players' association is "diametrically opposed" to the United States National Basketball Association (NBA) policy, which went into effect in January. Under it, any player convicted of heroin or cocaine use, or sale of such drugs, is expelled. His career is over.

There was a three-month amnesty period before the new policy went into effect, during which professional basketball players with drug problems could request treatment and be exempted from the expulsion policy.

Interestingly, the National Basketball Players Association backed the owners in their "get tough" policy. In a *New York Times* article in October 1983, right after the policy was made public, Bob Lanier of the Milwaukee Bucks, president of the players' association, explained:

"The overwhelming number of (basketball) players are not users of drugs, and once and for all we want to be able to convince the public. This not only makes it easier for me and others in the league to hold our heads high when appearing in public, but it also helps our sport."

Mr Lanier added that "80% of our players are black. The kids in the inner cities idolize NBA players, and we felt it critical that these children hear our message loud and clear. NBA players won't use drugs, and, if they do, they will be kept out of the league."

Says baseball's Mr Belanger, however, "if a player has a problem, we want to get him help. That has to include education as well as treatment. And both sides, owners and players, have an interest in helping our people."

Meanwhile, baseball has been smarting from the drug convictions of several stars in recent months.

Last fall, four members of the Kansas City Royals — Vida Blue, Willie Aikens, Willie Wilson, and Jerry Martin — drew prison sentences and fines for cocaine possession.

In another case, Los Angeles Dodgers pitcher Steve Howe, who has been treated for drug dependence more than once, was fined by Dodgers management.

Although several of the clubs refer drug-abusing players to employee assistance programs, there has been no consistent policy on drug use in major league baseball.

Some observers of the professional sports scene are worried that sports celebrities might lose their civil rights when drug abuse is suspected by their employers.

In both the US National Football League and the NBA, aggressive security investigation may include the hiring of private detectives, wiretaps, and mandatory urinalysis.

A February article in the *New York Times* reported "athletes are becoming increasingly fearful that they are under surveillance in ways that compromise their privacy or civil rights."

However, baseball continues to try to work out a policy that will respect the individuality of the abusing player as well as protect the game.

Heading the joint committee are Donald Fehr, acting executive director of the Players Union, and Mr MacPhail.

Murder trial traces stages in career of an addict

VANCOUVER — Testimony at a murder trial here has painted a stark picture of the life of a narcotic addict.

A man charged with second-degree murder testified that he began using stolen cough medicine when he was 16.

"It only takes 30 seconds. I just run in and grab some 80-ounce bottles," he said. "At first it took one or two ounces to get high. Then it was 15 ounces."

The next step was breaking into drug stores at night and "hitting the DD" or dangerous drugs drawer.

The man received sentences for breaking and entering in 1975, 1980, and 1981.

He was released in March, 1982, and supported himself and his habit, he said, by further drug store break-ins.

But Vancouver drug stores were not such easy targets then. Before 1981, eight out of 10 stored "good dope," he said. "When I got out in 1982, drug stores were harder to do." The percentage dropped to one in 10.

He became increasingly professional: "I always try to keep an up-to-date CPS book around," he said, referring to the Compendium of Pharmaceuticals and Specialties manual.

He was also guided, he said, by the red-circled "N" on labels, indicating the drug is classified as a narcotic.

He supported a habit that required the equivalent of "a bundle," or 25 caps, of heroin a day.

One of the drugs he had on hand the day of the alleged murder was stolen Lomotil (diphenoxylate), an anti-diarrheal drug that contains a synthetic opiate (The Journal, July 1982).

The defendant testified that a drug dealer-addict forced his way into his house, brandished a gun and demanded heroin.

The intruder rejected the offer of Lomotil and escalated his threats.

Another gun came out and, 10 years after he stole his first bottle of cough syrup from a drug store, Terry Feliks shot and killed a man.

Having argued that he shot in self-defence, he was acquitted.

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

'I deal with consequences,' says reader

Behaviorists unmoved by failure

I wish to protest bitterly your unremitting campaign to promote "controlled drinking." I have been a counsellor of alcoholics for 35 years, and it is such as I that have to deal with the consequences of such nonsense.

These people die in misery and despair, and your researchers move on to other fields.

Alcoholism is more and more certainly seen as a physical illness coupled with a psychological dependence. The illness is physical, and the symptoms are behavioral. Once the behaviorists see the symptoms, they feel that their particular discipline is the answer. The trouble is, of course, that treating the symptoms of any disease does not deal with the disease.

When you pit the nickle-and-dime research that they love to quote against the literally millions of alcoholics who have dealt with their illness by abstinence, there is no comparison.

One feels that the behaviorists are dealing with white rats, and are moved just as little by the failures of their theories.

Since you have given the behaviorists two pages in **The Journal** (Feb), I will expect the same for the proponents of abstinence. But I really don't expect it to happen. Your bias seems unexplainable.

Robert C. Hickle
Waverly, Iowa

Ed Note: *The February issue of* **The Journal** *carried a Back Page interview with Dr David Smith, a leading expert on the treatment of addictions and a proponent of the disease model and of abstinence. The Behaviorists (Pages 9-10) reported the views of a conference-panel on treatment.*

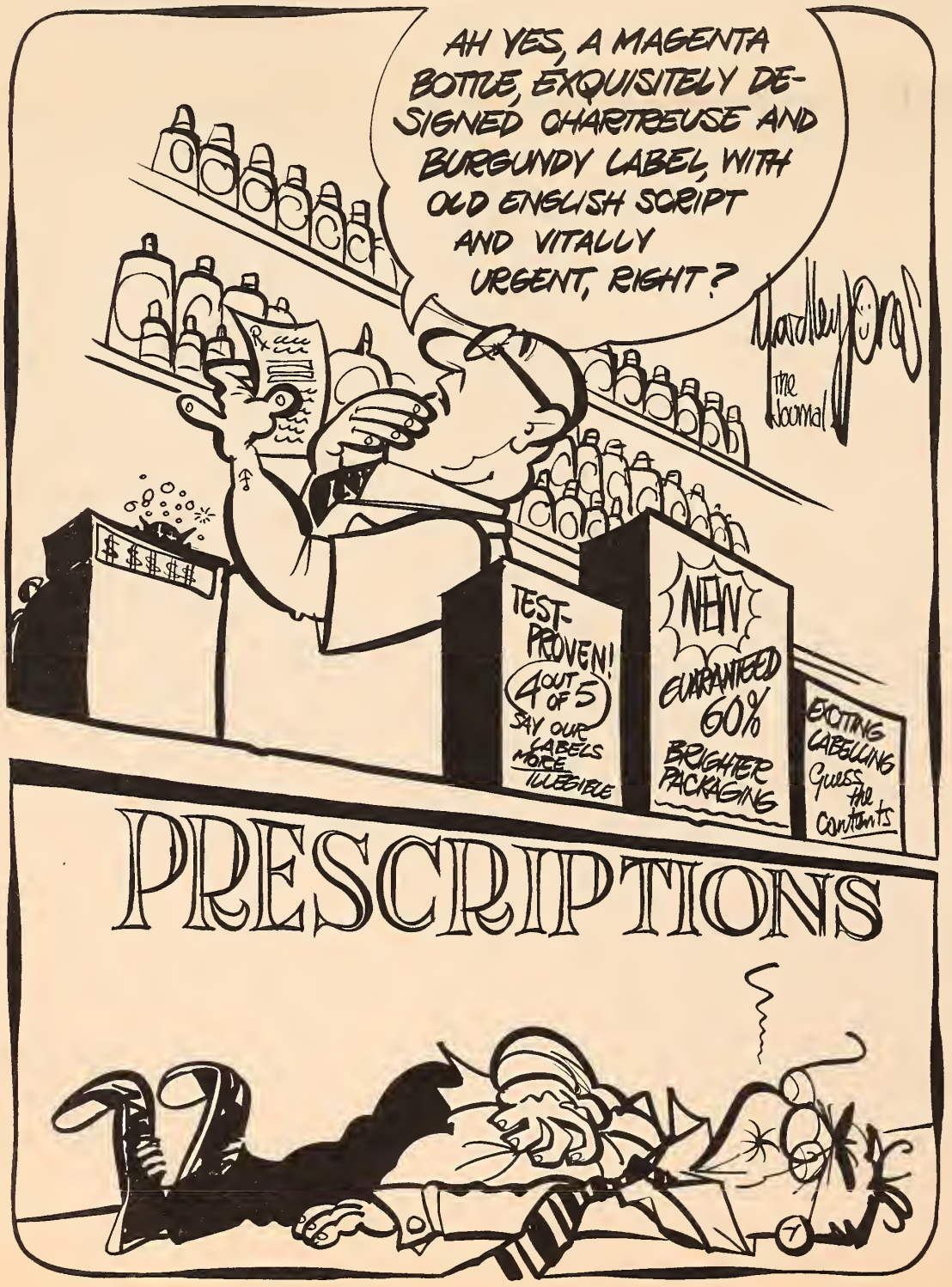
'Vociferous minority' given undue credence

Harvey McConnell's interview with David Smith, Addiction as a Disease? The collision of prevention and treatment (**The Journal**, Feb), lends undue credence to "a vociferous minority of lay people in the prevention field," as you term them.

To infer that this group and its views are representative of the field of prevention, through the title of the article, is a disservice. Dr Smith's example of the legitimate conflict between prevention and treatment is, in my opinion, poor as well. There are individuals in the prevention field who rely on scientifically-substantiated information to determine their positions on issues.

I would assume that my counterparts in the treatment field would be sensitive to having a nameless group of "censorship-type people" representing them in a collision termed legitimate.

Rich Linehan
Prevention Specialist
Office of Alcoholism and Drug Abuse Prevention
Augusta, Maine



Delighted reader congratulates TJ

I was delighted to read about the first-place Award of Distinction given to **The Journal** and reported in the January issue. The broad coverage that you and your staff achieve constantly fills me with wonder.

It is perhaps noticed by me more now that I am an old retiree, than when I was actively engaged in the work of the Addiction Research Foundation.

I am grateful for the opportunity of scouring **The Journal**'s pages every month.

Ron Purves-Smith
Victoria, BC

Terrific examples

I'd like to congratulate **The Journal** on winning first prize (category 2B) at the recent Health Care Public Relations Association awards ceremony (**The Journal**, Jan).

For my "terrific examples" file, I would love to add your award winning entries.

Again, congratulations!

Pauline Jackson
Public Relations Officer
The Princess Margaret Hospital
Toronto, Ontario

Terminology an unpleasant surprise

I was unpleasantly surprised to see the use of the terms "soft" and "hard" drugs in Michael Kesse's article on drug abuse in Israel (**The Journal**, Feb). As a professional field (chemical dependency), haven't we finally matured to the point of no longer using such misleading and meaningless terms? I guess not.

Barry Wolf, PhD
Director of Treatment
The Salvation Army
Harbor Light Center
Detroit, Michigan

The Journal **welcomes Letters to the Editor.**

Letters bearing the full name and address of sender may be sent to: The Journal, **33 Russell St, Toronto Canada M5S 2S1.**

Alcohol, Drugs, and the Doctor

— A symposium of opinion —

The "impaired physician" is a source of concern today for both the general public and the medical profession.

It is hard to escape the impression that there are doctors making their daily rounds "high" on alcohol or other drugs — their clinical judgements clouded, and their patients at risk of misdiagnosis, serious injury, or perhaps even death.

Treatment is fast becoming a medical sub-specialty — and big business. Proprietary hospitals welcome the impaired physician patient.

Yet, drug and alcohol abuse in the medical profession is not new.

The Homewood Sanitarium in Guelph, Ontario, opened a hundred and one years ago as "an asylum for the insane and inebriates." One of the earliest hospital-based addiction treatment centres, it has, since the beginning, counted physicians among its patients. In those early days, opium was the drug of choice.

There was, however, no firm evidence then, and there is none today, that addiction is any more prevalent among physicians than among their socio-economic peers. Nor is there evidence that patients are significantly endangered by their doctors' drug or alcohol abuse.

In this special section, The Journal's contributing editor Harvey McConnell asked a number of experts in Canada and the United States to assess the subject.

The consensus:

- There is no difference between patterns of abuse among physicians in Canada and the US, although professional bodies in Canada try to keep publicity to a minimum.
- Doctors are not over-represented in substance abuse populations.
- Doctors experience no exceptional stresses that could drive them to drugs or alcohol.
- The problem is probably not on the increase, although it has more public visibility than in the past.

The experts point out that the drug most commonly abused, other than alcohol, is Demerol (meperidine, pethidine in Canada) a synthetic narcotic analgesic, although use of fentanyl (Sublimaze), another synthetic analgesic, is increasing.

And most assume that doctors who grew up in the post-1960s drug culture experimented with illicit drugs, and that this accounts for the fact most cocaine abuse by physicians is in the younger age group.

There are some differences between medical professionals and the general population:

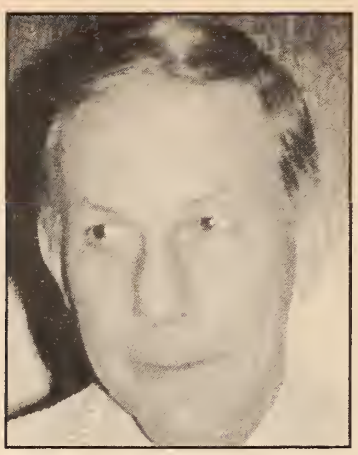
- Doctors have ready access to drugs, although the risks of their being caught diverting them is now much higher in both Canada and the US than it was a decade ago.
- They use their medical knowledge to calculate drug dosages, and the anecdotal evidence is that most of them can function normally, their clinical judgement unimpaired. When judgement does begin to falter, many realize it and take steps to minimize the risk.

Because of the cachet society confers on certain professions, including medicine, doctors run an attendant risk of public, as well as professional, opprobrium if their errant behavior becomes known.

Above all, they will take extraordinary steps to hide their drug or alcohol dependency for fear of losing their escutcheon — the licence to practise. It protects everything — profession, prestige, and income. To have it taken away, doctors believe, is to lose everything.

→

Alcohol, Drugs, and the Doctor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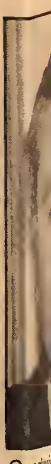

Goodwin

Edward Senay

Edward Senay is professor of psychiatry, University of Chicago, and executive director of Substance Abuse Services Inc in Chicago. He says that while the exact size of the problem is unknown, "it is significant enough that probably most hospitals have one or two physicians, and most communities probably have a few physicians, addicted to a variety of drugs."

What they are addicted to depends on their age and the drug cultures in which they were involved — alcohol, barbiturates, marijuana, cocaine, or heroin.

While figures like "one in every 30 physicians is addicted at some time in his life," have been suggested, "this seems excessive to me," says Dr Senay. "I just don't extrapolate from the patients I see to rates as high as that.

"I think we probably have a little bit more than people who are our socioeconomic peers, but not that much more, and the only reason for that would be availability."

Young doctors have grown up in the drug culture, and with a point of view about the role of intoxicants in their lives, Dr Senay continues, "so I don't think there is any dearth of young physicians who are doing cocaine and that kind of thing. It doesn't take too many physicians indulging in crazy behavior to get everybody uptight, because people don't forgive us much."

Doctors choose Demerol for good pharmacological reasons, he says. "The metabolite in Demerol is just stimulating enough so they don't get the down effects one would get from being hooked on other narcotics, that's the conventional wisdom. Those doing surgery or things like that would not be able to be very effective if they were using other drugs that would cause them to nod off, so traditionally Demerol has been the drug of choice because it is not narcotizing."

Dr Senay, though, has no doubt that if he took Demerol, "I couldn't function, and I don't know how the hell they do it. But the bottom line is that one would expect a lot more impairment in functions than seems, in fact, to be the case.

"What is very striking to a practitioner in this business, such as I am, is the relative lack of impairment despite very healthy levels of intake, and they become tolerant to the effects of the drugs."

A sharp contrast between street- and physician-addicts is that physicians continue to be active in the workplace, "and contrary to what you might think from the pretty hefty levels of intake, their ability to function seems to be relatively unimpaired. It is very striking that there is not more impairment than there is, and this seems to be true in a lot of addicted nurses too."

Dr Senay does not agree with the idea that doctors start to take drugs because they have more stress than other people.

"Sure, we've got stress, but so do a lot of people in our society. Flying an airplane around is a pretty stressful business if you're going to stake 300 lives on the line.

"And we get things that a lot of people don't get who have equal amounts of stress, and that I think counterbalance: namely, money and status. And these are very important buffering factors."

Reporter: Harvey McConnell

Editor: Anne MacLennan

Physicians take drugs for the same reasons as anyone else, says Dr Senay. "I don't think there is anything very specific to being a physician. Physicians have the same kinds of life crises as anyone else: their wives, or their husbands, have problems; their children have problems; there are money problems and status problems and all the stresses anybody else has."

He does not agree that many patients fail to notice if their physician is having drug problems. "Patients are not stupid, and if somebody is intoxicated from anything, I think they have a reasonable chance of picking it up.

"Ultimately there is no way of protecting everybody all the time from irrationality."

Frederick Glaser

The ratio of physicians impaired by substance abuse is probably similar in Canada, the US, and Britain and not significantly different from the size of the problem in the general population, believes Frederick Glaser, psychiatrist at the Addiction Research Foundation (ARF), Toronto.

Over a three-year period, Dr Glaser and colleagues studied in depth 36 Ontario physicians — one of them female — prior to their admission for treatment. The researchers are now using their findings to prepare future studies.

Dr Glaser says he and his co-workers are "not impressed that alcohol or drug problems are any more frequent among physicians than among other people, but to say that is not to minimize the problem."

Patient care is probably not markedly affected, he says, because impaired physicians focus almost exclusively on ability to practise, "and they preserve that at all costs."

In one case, paradoxically, the ARF research team found one physician used drugs so that he could practise efficiently. He told the team: "I had a great responsibility toward my job, and I persecuted my body in order to remain as a physician. My body was not made for long hours and strain, so I used drugs and alcohol to get to my goal: to be a good physician."

Dr Glaser adds: "I don't think that is simply a rationalization."

Although the stresses accruing to physicians may appear to be unique, many of them are not, and generally also apply to other groups, says Dr Glaser. "Many of the alleged stresses, such as death, are hardly unique to policemen, the military, clergy, or even morticians.

"And many physicians do not have contact with death at all, so the percentage who deal with life and death situations is small."

Dr Glaser says one interesting factor to the researchers "is that many tend to get locked into the role of being a physician, and that becomes really their only viable role in life and, therefore, that role tends to get preserved beyond any others.

"They seem to have this one role, and it is very adaptive when they are functioning in a professional setting, but it is very maladaptive outside a professional setting."

Many addicted physicians control their use carefully and refrain when they know they will be needed. One physician in the study took narcotics to get to sleep, but kept a syringe filled with a narcotic antagonist by the bedside.

Dr Glaser says the physician reasoned that, if he were called in the middle of the night and sounded groggy, it would be attributed to his just being awakened. If he had to go out, the antagonist would reverse the effects of the narcotic in minutes. "He would look a bit washed out, but the reasoning would be, of course, that he had been asleep."

No one, except the physician's wife, who saw him inject himself, ever suspected his drug use, and he was never caught. He finally decided his behavior was silly and voluntarily sought help.

Dr Glaser has strong feelings about the trend in the US, and which is being followed in Canada, to using the confrontational approach to physicians suspected of drug and alcohol use.

"This is based on the belief that one is dealing with a disease, one of the characteristics of which is denial, and that this type of approach is required to break through denial.

"This approach involves the assumption that any sort of a problem with alcohol or drugs either already has, or very shortly will, inevitably lead to difficulty in the practice of medicine. Therefore, the people who employ this approach have no compunction about using it and about basically taking action against the status of a person — an alcoholic or an addict — rather than against the acts of that person.

"In my view, that is against the law."

Denial is a normal mechanism everyone uses, "and if we didn't, we would be in trouble," Dr Glaser adds. Denial is also, to some extent, a person's right, and if he does not choose to be treated for whatever is wrong with him, in so far as that doesn't impinge on other people, that is his business. "You cannot assume that, because physicians have an alcohol or drug problem, they are having trouble practising medicine."

Dr Glaser believes that if there is no evidence a physician has done anything amiss in practice, such confrontation is not only illegal but unethical as well. The issues should be dealt with separately, although they tend to be grouped.

This is leading, he says, "to a sort of vigilante mentality where this group of people see themselves empowered to stamp out these problems in the medical profession. I think this is a very unfortunate state of affairs."

High quality treatment should be made available and, from the troubled physician's point of view, accessible. Then, it is up to the individual to decide whether he or she is going to take advantage of it.

Dr Glaser adds: "It is important to reflect on the fact that maybe 95% of the poor practice of medicine is not related to alcohol or drug use, but is simply poor practice of medicine, just as most violent acts are not related to abnormal mental status."

'. . . many physicians do not have contact with death at all, so the percentage who deal with life and death situations is small' Glaser

Merville Vincent

Since 1960, more than 300 addicted physicians have been treated at Homewood Sanitarium, a private psychiatric hospital in Guelph, Ontario. Merville Vincent, executive director, says it is impossible to know whether this group is representative of the profession at large.

"Nobody has ever done a prevalence study, that I am aware of, to find out what the overall incidence is. I usually say it really doesn't matter whether the figure is 5% or 20%. If it is 5%, it's a real problem for those 5%.

"But there is no question that alcoholism and drug dependency are real problems in the medical profession, no matter what the numbers are and, therefore, we should be concerned about it, and we should try to be helpful. (**The Journal**, Aug 1978)

In one study of 93 physicians admitted to Homewood, 30% were primarily dependent on alcohol, and 27% were primarily addicted to other drugs.

For more than 50% of the alcoholic doctors seen at Homewood, mixed addiction is a problem.

"This is very true in the general population and, I think, is even more true among physicians who become addicted to alcohol. They try to begin to treat themselves, realizing they are in difficulty with alcohol; they try to cut back and substitute, typically, minor tranquillizers; and they end up hooked on both.

"And, typically, the alcoholism came first but not always."

Dr Vincent recently saw a patient whose major concern over the years, going back to internship days, was insomnia. "The first thing he began to use was Noludar (methyprylon) for sleep, and then he began to add alcohol. And, by the time he gets here, it is a mixture of alcohol and minor tranquillizers and so on."

Usually, he says, as long as doctors have control, they are careful about when they drink or take their drugs. They make sure they're not on call. "But once they lose control — it is often at that point that doctors come into treatment."

In the last four or five years, Dr Vincent has begun to see a small group of younger physicians who experimented with drugs before entering medical school. Some "have a real curiosity about all the drugs they prescribe. I have seen several who have gotten into real trouble.

"In my day, probably nobody started med school who had been experimenting around with drugs before they got in, because, at that point, that would mean being a street addict, and if you were a street addict, you probably didn't get into med school."

A study of all female physicians admitted to Homewood between 1960 and 1974 (13) showed a lower incidence of alcohol and drug abuse than among their male counterparts.

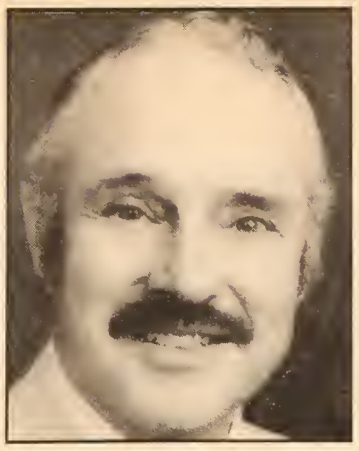
Although the sample was small, the percentage admitted with a primary diagnosis of alcoholism was 7.7% compared to about 30% for male physicians admitted. There was also a lower incidence of drug addiction.

On patient safety, Dr Vincent says: "I don't blame people for being concerned. But the safest place, probably, would be an operating room; this would be the last place that somebody gets to function when they are intoxicated.

"The situation where the impaired doctor is more likely to be a threat to the public well-being would be in his own office. There, it is more likely to be missing a diagnosis, rather than cutting the wrong leg off, or that sort of more dramatic thing.

"I think the concern is the individual physician who isolates himself — as happens with addiction. When doctors become aware of their problem, they tend to back


dwin


Talbott


Smith


Siegel


Steindler

off from the hospital and become more and more isolated. They become lonely, isolated individuals."

Donald Goodwin

It is a myth that doctors are particularly susceptible to drug abuse, alcoholism, or suicide, says Donald Goodwin, chairman of the department of psychiatry, University of Kansas Medical Center, Kansas City, Kansas.

"It is like the stereotype of the drunken Indian. All it takes is one drunken Indian for you to be a strong believer that Indians can't drink. And all you need is one tipsy doctor at a party, or just to have alcohol on one's breath, to confirm the stereotype," he says.

"I don't think there are any data that indicate doctors, dentists, and nurses as a group are particularly susceptible to drug abuse in recent years, and the only data you had in previous years was anecdotal.

'. . . the family goes, the community goes, the money goes, and the health goes — before the profession goes.'
Talbott

"I think the old days, which weren't too long ago, when doctors could get unlimited supplies of morphine and other dangerous drugs, and prescribe out of their offices with no control, are past."

Surveillance by the US Drug Enforcement Administration (DEA) of Schedule Two prescription drugs, such as opiates, barbiturates, and amphetamines, is a major factor, Dr Goodwin points out. There is much less office dispensing, and hospitals are much more closely monitored, "so that those who are trying to syphon off Schedule Two drugs are running a very large risk."

As for the stress hypothesis, Dr Goodwin notes: "There appears to be no connection between stress and use of drugs. Many people under a great amount of stress don't use drugs, while people who appear to have very little life stress, such as youth in the 1960s, can use very large amounts."

Evidence is non-existent that alcoholism among physicians exceeds that of other occupational groups. Dr Goodwin: "It is like the myth of a high suicide rate among doctors. The suicide rate among doctors is no greater than it is in the general population when you adjust for age. It is like the other myth — that suicide and depression among people show an increase at Christmas."

On the other hand, Dr Goodwin points out, "there is no question that impairment of physicians occurs, and it has become a big deal in the profession. 'Impaired physicians' has become almost a buzz word, and it has created a whole movement — with conferences and proprietary alcoholism hospitals set up for them. And with some impaired physicians, it has become almost their field."

Douglas Talbott

There are those, however, who consider the problem to be very serious. For instance, Douglas Talbott, director of the Ridgeview Institute, Smyrna, Georgia, who, in 1976, started the pioneering impaired physicians program for the Medical Association of Georgia.

A recovering alcoholic, Dr Talbott says the institute has now treated more than 650 physicians from 39 states and five Canadian provinces, and is currently preparing to publish a two-year follow-up study on the first 200 physicians treated.

"I think it is a tremendous problem. Fourteen per cent of all physicians are going to develop, or have developed, chemical dependency," he declares.

Almost all the institute's physician-patients are poly-drug users. "It is very rare for us to see uni-drug use any more." While many have abused Demerol, "we are seeing a lot of Percodan (oxycodone) and fentanyl use, and an increasing rise in cocaine use among doctors in their 30s, as well as marijuana and alcohol in this age group."

Dr Talbott believes a major reason for growth of the problem is the influx of new doctors. "In the older physician, alcohol is the drug of choice, while new physicians are coming through the drug culture; they have always used drugs, it has been a part of their way of life. Abuse is much more common in the new generation of physicians."

The dynamics of the problem in physicians are such "that in our experience the family goes, the community goes, the money goes, and the health goes before the profession goes. There is no question that their judgement, reasoning, and insight is not as good as it was when they were chemically-free, but actual patient death due to the physician's using drugs is rare.

"A physician can be knocked out by other components in his life before it gets to his profession."

Dr Talbott will not admit a physician for treatment for less than four months.

"We need four months for doctors — more than other people — because I think the dynamics of denial are much higher in physicians," he explains. "I think with physicians it is tremendously hard to break through the denial, but once you do break through, in many ways they are better patients."

In the yet-to-be published study, Dr Talbott says the two-year follow-up of 200 physicians — with recovery measured as two years' abstinence, and effective, efficient, and happy recovery in all spheres of their lives — is running at 93% success. "We don't talk about a relapse rate because some of our individuals have relapsed for 24 hours, but we have picked them right up again."

Dr Talbott says a critical factor in treatment is "if the physician does not get into Alcoholics Anonymous or Narcotics Anonymous, it doesn't work."

David Smith

Medical director of the Haight-Ashbury Free Medical Clinic, San Francisco, David Smith also considers the problem "has been serious and endemic for a long period of time. It is an occupational hazard, and I feel that the incidence of prescription narcotic addiction is four to six times the national average.

"The problem is spread uniformly across the physician population, and it is found in rural areas on a per capita basis as much as in urban areas. However, I don't think the problem is increasing, except in one area: a rising use of cocaine among young physicians." (**The Journal**, Nov, July 1983)

Dr Smith, who is involved in several projects in California for treatment of impaired physicians, says that almost always, after lectures he gives on the problem to physician groups around the country, he is approached by a physician "who talks about an individual problem that a friend has."

Some physicians, in fact, are bellweathers for testing initial claims by the pharmaceutical manufacturer and the Food and Drug Administration that a new drug is non-addictive.

Dr Smith: "We have been able to predict certain possible street drug patterns by observing what drugs physicians get involved with. The classic example is Talwin (pentazocine), which the drug company said initially was non-addicting."

Although he and his colleagues were treating physicians "strung out to the eyeballs on it, nobody would believe us until T's and Blues came along." (**The Journal**, Nov 1983)

Again, he finds that doctors will protect their jobs to the last, and that addiction interferes relatively little with professional performance. "Although in no way endorsing the behavior, it is wrong to say there is wholesale patient devastation, or to say that as soon as they start using it, it interferes in the workplace.

"It is part of their denial system. I have seen situations in which the rest of their lives are a total mess, and they are still functioning well in the workplace, with all sorts of protective mechanisms. When signs and symptoms start appearing in the workplace, that is a late stage."

Dr Smith believes alcohol has a more disruptive effect than narcotics. "I see 50 addicts a week in detox, and it has always amazed me that while a guy intoxicated with alcohol will have slurred speech and a staggering gait, and a guy abusing cocaine will be paranoid and hallucinating, a guy who has just shot up heroin or Demerol, although the pupils will be pinned, will sit there and carry on a perfectly normal conversation."

Abusing physicians, using their pharmacological knowledge, will titrate doses so the drug does not interfere with performance. They can look and function relatively normally as long as the doses are regular and adequate.

Dr Smith says Demerol-abusing physicians will eventually get caught out — by diverting too much of the drug, by having the supply stopped and going into withdrawal, or by taking too high a dose and going into an atypical Demerol intoxication seizure.

One physician successfully hid his addiction from his wife "until one night he had a Demerol intoxication seizure, and she found him on the floor in the bathroom with the needle and syringe stuck in his arm," Dr Smith recalls.

Doctors will dose themselves in bizarre ways. "We had one young doctor who took an IV (intravenous) bottle, laid on the floor, and gave himself a 24-hour intravenous infusion of cocaine. He called it 'recreational drug use,' and believed at the time it was. Today, he can't believe he did such a bizarre thing.

"But when you think about it, he used his medical knowledge to give himself a uniform dose, he did not have to inject himself repeatedly, and he ran little risk of overdosing."

Dr Smith believes medical students must be taught that addiction "is an occupational hazard, just as a coal miner needs to know black lung is an occupational hazard."

Help must be directed at physicians, such as confidential phone lines, "because physician addicts don't congregate." It is also vital to work with the families of impaired physicians.

Ronald Siegel

Psychopharmacologist at the University of California at Los Angeles Medical Center, and an authority on cocaine abuse (**The Journal**, July 1983), Ronald Siegel has seen only a handful of cocaine-addicted physicians in his practice.

All indications are that many young doctors use cocaine, "but they are notoriously reluctant to see others for that problem," Dr Siegel says. "I have only seen freebas-

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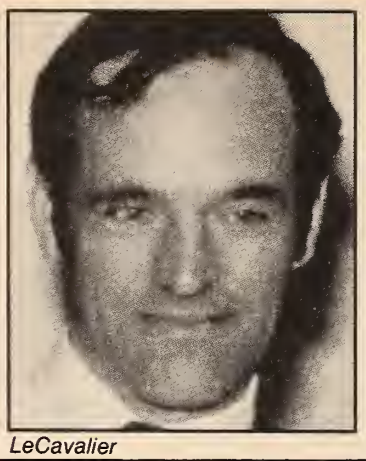
Alcohol, Drugs, and the Doctor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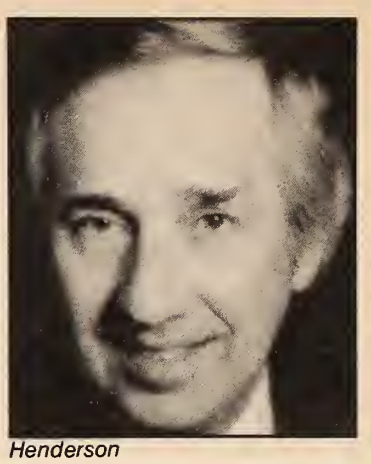
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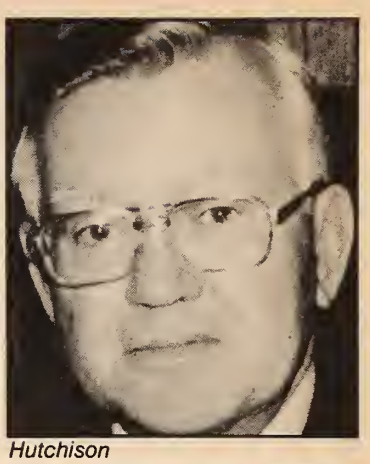
Hutchison

ers or intravenous shooters, but I have never had one physician come to me for any assistance, who is snorting. I am afraid to think many are."

He has treated a few radiologists heavily involved in freebasing who continued to work, "and I really get concerned about the accuracy with which they do their diagnoses." All physicians sought help because their clinical ability was hampered.

Dr Siegel believes cocaine snorting would not necessarily affect clinical ability, although this depends entirely on patterns and chronicity of use. A number of dentists taking part in an out-patient survey of drug use, but who are not patients, reported they snort cocaine and are unaffected. "At least, that is what they report. We don't have an independent verification of their performance."

While weekend snorting of cocaine may not affect a physician's clinical ability, a weekend of freebasing is a different matter: "They don't show up on Monday morning, it's as simple as that."

E. M. Steindler

The American Medical Association (AMA) has two concerns about impaired physicians —the human one of dealing with the problem, and the professional one of the effect the addiction has on performance.

With these concerns in mind, says E. M. (Manny) Steindler, director of the AMA Human Behavior Program, Chicago, "we have encouraged state medical societies to initiate programs to identify them and to encourage them to enter treatment. If that does not work on a voluntary basis, then they (the societies) should attempt to work with the various disciplinary and licensing boards to see if they can bring some pressure to bear on the physician to relinquish his licence and to go into treatment."

Mr Steindler says a major problem "is coming by good, hard, epidemiological data. One reason is that there is no generally accepted definition of alcoholism and drug abuse/dependence, and these disorders don't necessarily equate with impairment."

There is no question there have been instances where patients have been harmed, "but my impression is that it is not as prevalent as stories might indicate," he says. An impaired physician "may forget to keep appointments, keep sloppy records, may fail to diagnose something properly or in time, which may not cause the patient to lose his life, but may result in less than optimal patient care."

Monitoring by the US DEA has had a good effect on the prescribing habits of doctors in general. As for addicted physicians, "there is no evidence they are poor prescribers because of their habit. In fact, some may be overly cautious because they don't want to draw attention to their own problems."

Mr Steindler does not believe that the patient population should be apprehensive about the medical care they receive.

"Statistically, the chances are that their physician is not impaired, and, even if someone has a physician with a problem like this, there is a better opportunity and better chance now that it is being addressed and dealt with than ever before."

The AMA has held several conferences on impaired physicians with another planned for September in Meadowlands, New Jersey.

Jacques LeCavalier

Canada's Bureau of Dangerous Drugs, with its nationwide monitoring of wholesale and retail sales of controlled drugs, and of prescribing and purchases by physicians, can be more aggressive than the US system in seeking out physicians who are abusing drugs.

"We can detect the problem more quickly and tackle it more quickly," says Jacques LeCavalier, Bureau director. "The key factors in curtailing the problem of drug-impaired physicians are prevention and early detection."

In the past decade, the Ottawa-based Bureau has observed that among all health professionals, including dentists, there has been an increase in narcotic use. "The proportion of impaired physicians to the general population is 10 to 30 times greater," claims Mr LeCavalier.

Although similar monitoring systems are being set up in some US states, on a statewide basis — Wisconsin is one of the leaders — they still lack some of the options available in Canada. (**The Journal**, Dec 1983)

Mr LeCavalier says that if the Bureau finds prescribing and local purchases seem to be unusually high, physicians are contacted and asked to explain. Sometimes they will admit to using drugs, but often they deny it.

Mr LeCavalier: "Initially, unless we can identify overt dangers to the public, and if they are frank about their situation, we will give physicians an opportunity to seek adequate treatment. We will also inform the provincial licensing authorities."

If the particular drug use pattern seems to recur, or there appears to be a danger to the public, the Bureau can notify manufacturers, wholesalers, and pharmacists not to accept any order or prescription for controlled drugs from the practitioner. The case is generally referred to the provincial licensing body, and the physician's licence to practise is removed.

"By and large," he believes, "this program of consultation between the federal and provincial authorities is probably a model of cooperation. We are aware of the problem of the drug-impaired physician, and we are now in the process of trying to establish a common strategy with provincial and treatment officials toward early detection, correction, and prevention."

Mr LeCavalier says the Bureau knows it has had some success with its initial approach to physicians about their prescribing habits. Many immediately stop their drug use or seek medical treatment without the licensing authorities having to step in.

Mr LeCavalier says he has no reason to believe use of drugs differs between the US and Canada "although we, perhaps, have more control in Canada than they have in the states regarding distribution and use of drugs, particularly narcotics and controlled drugs."

John Savage

A major aim of a committee of the Nova Scotia Medical Society is to include pharmacists in the impaired physician equation.

John Savage, chairman of the society's committee on alcoholism and drugs, points out that under the law a pharmacist can refuse to dispense a prescription. The committee would like to see a situation "where, if a pharmacist does not like a prescription from a doctor for a bottle of Demerol, the pharmacist should say so."

Age is key. "If you have a 61-year-old pharmacist brought up to believe everything the doctor ever ordered is right, then the pharmacist is not going to rock the boat. But the younger pharmacists, whose appreciation of the situation is very different, I think hold the key."

Dr Savage says the attitudes of health professionals must be changed, "but the idea is not popular with doctors, who still think they are the important person, and this is part of the myopia that characterizes all doctors' organizations."

Dr Savage notes that there are no official figures to indicate how many physicians in the province are in treatment. In addition, "we have a conservative society, and it is reflected in the policies of the Nova Scotia Medical Society and, therefore, it is not easy to uncover, discuss, and deal with issues."

He does not believe patients are at risk from the impaired physician "other than the normal risks a patient runs when they put their lives in the hand of a doctor."

A major stumbling block in Nova Scotia, as in the rest of Canada and the US, and in medicine in general, "is a reluctance among all doctors to apprehend a colleague early on. 'There but for the grace of God go I,' and that attitude tends to make doctors less critical of their colleagues than the reality deserves."

William Henderson

Registrar of the Ontario College of Physicians and Surgeons in Toronto, William Henderson believes there is a tendency in the media, "and those who pick this up as a human interest or public interest story, to present it in a light which is totally out of context with the effort being made in Ontario."

The Ontario College program "is directed to increasing the level of awareness and understanding of the problems of misuse of alcohol and drugs by physicians, with a view to creating a climate that will enable them to take advantage of every opportunity to get help for themselves and their colleagues."

The fact physicians may have problems and need help, and that there are programs to help them, "does not carry the implication that they are impaired to a degree that is a serious risk to the public. This is the usual implication that is taken out of any such program material when this is aired in public stories," Dr Henderson continues.

The aim, he says, is to get better recognition of the condition as a disease, move in time, and not wait until it becomes a serious concern.

Dr Henderson: "We find physicians do have special needs. Their image gets in their way of seeking help, they can't talk to their colleagues, and they feel they are going to lose face and respect. This is a negative attitude and inappropriate thinking, but it is there. Also, they are self-employed and there are financial implications.

"What we have tried to do is highlight these things and develop a sensitivity to those kinds of needs in programs that give particular attention to physicians. I think the response is very good."

Dr Henderson believes that as long as there is no clear evidence of impairment in the quality of patient care, the College will try and persuade the physician, every way it can, to get into a treatment program.

"If, however, there is serious concern about his ability to look after patients, then we will adopt formal procedures that are within our power." The doctor's licence to practise can be withdrawn, but this has only been necessary in a handful of cases in the past seven years, he says.

Dr Henderson points out the Ontario program differs from US programs, which seek out physicians who have problems. At the same time, a number of licensing bodies in the US are now looking at the Ontario system, where the College is both the licensing body and advocate for the troubled physician.

While it may seem a contradiction — the disciplinary body's being the advocate — Dr Henderson believes "the only way you are really going to reduce this incidence is by the profession policing its own. And unless the College takes an advocate role, I don't know how you expect anybody else in the profession to accept that kind of responsibility.

"The best protection is that the physician gets the help he needs."

John Hutchison

An opposite view to Ontario's is taken in British Columbia.

John A. Hutchison, registrar of the provincial College of Physicians and Surgeons in Vancouver, explains that under the Medical Practitioners Act, a committee of three outside physicians considers cases where there is reason to believe a physician is impaired because of addiction to alcohol or other drugs, or, who is emotionally ill. The committee adjudicates whether, following treatment, the physician is capable of resuming practice. (**The Journal**, Aug 1978)

Three years ago, it was decided to supplement this with an intervention program and, for legal reasons, a committee is appointed by the College from recommendations by the British Columbia Medical Association.

In this way, Dr Hutchison says, the College keeps at arm's length, "because it seems somewhat illogical that we should be both a disciplinary body and involved in this as well. You can't sleep on both sides of the bed."

The aim is to get to the impaired physician before he reaches the point when action should be taken under the law. "In other words, the committee gets in there, intervenes, gets treatment for him, does whatever it feels is appropriate, and doesn't tell me about it."

Dr Hutchison will not reveal how many physicians are treated this way. "After all, the name of the game is to protect the public. Once we have satisfied ourselves on that, let's help our colleagues."

Although no figures are revealed, Dr Hutchison says that, in the past three years, the committee has become so busy that others have been co-opted in various areas to intervene. "People give you figures that 15% of physicians are impaired in one way or another. I don't know where they get these figures. I say to people 'I am prepared to accept what you say but I don't believe it.' "

As to publishing the number of doctors who are impaired, Dr Hutchison asks: "What really does that answer other than the curiosity of the public? The aim is to deal with matters in an intra-professional way."

College disciplinary hearings are always held in camera, Dr Hutchison says, because they deal with "extremely confidential matters," and they believe patients and others involved should not be publicly exposed.

He admits the weakness: "People say, well, if we can trust you to do that, are you doing it? But if the alcoholic doctor is a sick doctor, should his sickness be publicized?"

INTERNATIONAL

England is trying jail for first offenders

Search goes on for ways to end drunk driving

By Thomas Land

LONDON — First offenders convicted here of driving under the influence of drink could be detained for up to four days in police cells, subject to the availability of suitable accommodation.

The ruling could save thousands of lives and is an example of English law being made in the courts, as well as in Parliament, in response to public pressure.

Disquiet over the mounting costs of drunk driving has emerged simultaneously during the past decade in many countries where judges, legislators, road safety experts, and educators are closely watching each others' examples in search of a lead to decisive action.

Parliament here enacted tough new road safety legislation last year increasing the penalties for drunk driving and tightening conviction procedures through the introduction of electronic breath tests (**The Journal**, June 1983). But it said nothing about jailing first offenders.

In the first seven months of the law, drunk-driving convictions increased at a rate of 37% over 1982's level of 75,000. A coordinated national police campaign against drunk driving, accompanied by an imaginative and forceful public information program, led to calls both inside and out of Parliament for yet stronger measures.

They were answered at a magistrate's court in the otherwise little-known community of Grays in Essex near London last December, when eight first offenders were jailed for up to four days.

Detention is not quite the same as a spell in prison, but a spokesman for the Magistrates Association commented: "The prospect of loss of liberty will operate on people's minds. . . . I should think that this is publicly acceptable."

The association does not lay down sentencing policy, but it encourages a consistency of approach. The advice it offers to magistrates throughout the land is therefore crucial. And the association's road traffic committee has just declared its approval of the use of custody as a deterrent to drunk driving, along the lines introduced at Grays.

"Being locked up for four days in police custody for the first time may well be sufficient to deter an offender from committing a similar offence," the association says. But it is concerned that custodial sentencing must still remain subject to the availability of proper accommodation.

'We apologize to the victims of traffic accidents for our faults, and we swear that we will never make such mistakes again.'

The power of its members to lock up first offenders on drunk-drive charges stems from the Magistrates Act. Britain's new road safety legislation prescribes the suspension of the driving licence of first offenders for at least a year. For a second offence within a decade, there is a maximum three-year disqualification, a fine of up to £1,000 (Cdn $1,860) and/or up to six months imprisonment. In addition, drivers with serious drinking problems can be disqualified for life.

About 30,000 Britons are killed or injured every year in road accidents involving at least one person with an alcohol level above the legal limit for driving (0.08%). This is part of a global trend.

Many of the offenders world wide are young people inexperienced both in driving and in drinking. Hence the global search for imaginative new approaches to end the slaughter on the roads.

The department of community medicine at St Vincent's Hospital in Fitzroy, Victoria, Australia, launched such a program eight years ago using the drunk-driving convictions of young people as an opportunity for early intervention to break a behavior pattern pointing toward alcoholism.

It has been adapted in many countries, including Canada and the United States, but the Australian program is innovative in that it operates outside the court system, seeking to inform drivers and not the police.

The global legislative reforms began in Scandinavia in the early 1970s, establishing a widening, long-term trend. Comprehensive road safety laws prescribing tough penalties — including prison sentences and permanent disqualification — have led to a 50% decline in traffic fatalities within a decade.

The drive to get tough with drunk drivers has probably gone furthest in Japan.

Offenders there are often jailed for three months or more, where they are ordered to chant in chorus each morning: "We apologize to the victims of traffic accidents for our faults, and we swear that we will never make such mistakes again."

Umbrella agency to coordinate UK alcohol effort

By Alan Masam

LONDON — Britain's Junior Health Minister John Patten has welcomed the establishment of the new National Agency on Alcohol Misuse (NAAM).

It is to replace and build upon the work of three former agencies in the UK — the Alcohol Education Centre, the Federation of Alcohol Rehabilitation Establishments, and the National Council on Alcoholism.

Mr Patten said the most helpful action could be undertaken locally, and that the NAAM would be well placed to stimulate the formation of more local councils on alcoholism.

Francis Gladstone, chairman of the new agency, said the NAAM would not be a killjoy agency advocating teetotal weddings.

"Our goal is to secure a comprehensive network of local care and rehabilitation services throughout England and Wales," he said.

Existing services are inadequate and under serious pressure. Thousands of Britain's alcoholics are unable to find suitable assistance. And where help is available, it is often "too little and too late."

Mr Gladstone said Britain could easily afford decent standards of service; the increase of funds needed would be a small fraction of the tax raised annually on alcohol.

Drugs in Norway will now bear danger signs

OSLO — All Norwegian pharmacies must now label dangerous drugs, including narcotics and opiates, with red "danger" signs. Substances which may affect a person's ability to drive, operate machinery, or carry out work in high-risk environments, must carry a red warning triangle on a white background.

The ruling followed a conviction by Norwegian health authorities that there was a large enough segment of the population sufficiently unaware of the inherent dangers of some drugs to justify the move.

Consequently, the Nordic Council established a committee to produce a booklet on drugs and traffic safety, and to make proposals for the labelling of a list of drugs considered to be especially dangerous.

The warning triangle was developed on this basis, and last year it was made compulsory for pharmaceutical manufacturers to print it on all of their listed products.

A similar label must also be applied by druggists when prescriptions are dispensed. Moreover, if doctors or dentists consider that drugs not included on the list are likely to pose a problem, they may instruct chemists to affix the red triangle.

Patients also receive an explanatory leaflet and are urged to consult physicians about the possible risks of driving or operating complex machinery while they are taking medications.

The appropriate director of health decides which substances should be labelled, but any drugs prepared from primary ingredients in the pharmacy, or if they contain any listed substances, are subject to the ruling.

All preparations for systemic use containing more than 100g of ethanol per litre must bear the danger sign, but there are no concentration limits for other substances.

Listed are drugs used to treat nervous ailments — ie, diazepam (Valium), sleeping tablets, motion sickness and allergy preparations, pain relievers, stimulants, drugs used in the treatment of epilepsy, and medications used in controlling high blood pressure.

The leaflets given to patients include the advice:

"Not everyone reacts to drugs in the same way. It is therefore important that you find out how you react to the medication you are using, whether you use drugs occasionally, periodically, or regularly. Your reaction is usually stronger during the first few hours after you have taken a dose and many medications will produce the worst side-effects (eg, tiredness and impaired concentration) during the first few days or the first few weeks of treatment.

"During this time you should, therefore, be particularly careful in driving."

NZ considering B1-enriched beer

By Pat McCarthy

AUCKLAND, NZ — The director of the Mental Health Foundation here has urged the addition of vitamin B1 to New Zealand beer to help prevent severe brain damage in alcoholics.

Max Abbott recommended using a procedure which he said enables vitamin B1 (thiamine) to be added without changing the taste or nutritional value of beer.

Dr Abbott, who made the recommendation after talks with medical researchers and clinicians in Brisbane, Australia, said the procedure had been described by Dr John Price,* acting head of the department of psychiatry at the University of Queensland, Brisbane.

While Dr Abbott acknowledged that adding thiamine to beer could be "relatively controversial," he said he understood a trial is being considered in one of the Australian states.

Adding thiamine could help prevent Korsakoff's psychosis — also called the 'Wet Brain Syndrome' — a severe form of brain damage associated with dietary neglect, particularly thiamine deficiency, and occurring almost exclusively in alcoholics.

"For reasons we do not yet fully understand, Korsakoff's psychosis is far more common in New Zealand and Australia than in other parts of the world," Dr Abbott said.

In New Zealand, people with the disorder make up 10% to 12% of all patients in psychiatric hospitals, he said. "This is because it often occurs quite early in life and there is no cure. As a result, they accumulate in our hospital 'back wards.'

"It is much cheaper to add thiamine to beer than it is to keep hundreds of people in hospital for an average of 15 to 20 years."

In Australia, about one-half of recent Korsakoff admissions were known to have consumed beer during the critical development stage. "We don't know the percentage here (in New Zealand) — we may find fortified wines are better candidates for thiamine enrichment."

Dr Abbott, a member of the Alcoholic Liquor Advisory Council's treatment committee, did research between 1978 and 1980 at the University of Canterbury, Christchurch, to identify Korsakoff patients more precisely and to find ways to improve their intellectual function. He was also a consultant to a psychiatric ward set up to rehabilitate chronic Korsakoff patients.

"Sadly, our efforts on the treatment side were largely futile. It is partly for this reason that we must look seriously at methods of prevention. Thiamine looks promising."

*Dr Price is at the Clinical Services Building, Royal Brisbane Hospital, Brisbane, Australia.

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NEWS

Saskatchewan program reduces celebration-time accidents

Grad parties put teens at high risk

REGINA — Over a six year period, 558 teenagers in Saskatchewan were killed, injured, or involved in alcohol-related accidents following all-night high school graduation parties.

And they're the tip of an iceberg, believes Bert Yakichuk, vice-principal of Miller Comprehensive High School here.

Broken down, the figure represents: 38 deaths; 207 auto accidents; 13 motorcycle accidents; 281 impaired-driving charges; four drownings; and 15 cases of severe burns.

Miller High, though, believes it has at least a partial answer.

For the past six years it has been involved in a program called Safe Grad, designed to cut drastically injuries and fatalities associated with graduation celebrations. Essentially, it's a parent/student/teacher monitoring program.

Mr Yakichuk describes the venture as a local solution to a local problem, but the implications range far wider, as other provinces and some states in the United States are discovering.

"When graduation takes place," Mr Yakichuk told **The Journal**, "risks escalate because many potential hazards often happen at the same time. The excitement and emotions of the event, the fatigue of a long day and night, inexperienced and exuberant driving, and the consumption of alcohol provide a frightening combination."

The idea for a mutual support project was born in the late 1970s when a Miller student's best friend was killed in an alcohol-related accident. The student went to the Saskatchewan Safety Council and asked for help.

The list of participants is now considerable — the Royal Canadian Mounted Police (RCMP), Saskatchewan Safety Council, Saskatchewan Alcoholism Commission, the City Police Forces of Saskatchewan, Saskatchewan School Trustees' Association, Saskatchewan Teachers' Federation, Saskatchewan Department of Health, and the Independent Assurance Adjustors of Saskatchewan.

Since the program's inception in 1979, says Mr Yakichuk, fatalities resulting from celebration parties have been virtually eliminated and accidents halved.

The key, he believes, is for schools to become involved with parents and local groups to promote graduation events which students can enjoy, but which do not carry the inherent risks of unsupervised parties.

"We started small with a group of about 50 students," Mr Yakichuk continued, "but this increased steadily until, in 1983, we had several hundred students involved — and the program is not just geared toward school kids. It's also aimed at parents and teachers.

"There has always been an emphasis on drinking and driving

Yakichuk Sebastian

throughout the year, especially at Christmas, but graduation involves a higher consumption of alcohol, and this applies across the country, not just in this province. Unfortunately, alcohol is associated with having a good time."

Mr Yakichuk says most accidents normally occur at late-night parties at pools or lakes, which too often result in drownings; at bonfire parties, with the concomitant risk of severe burns; and at country parties which involve "too much driving" and which can be located far from hospitals, medical resources, or police services.

"Any of these hazards can create a problem," he went on, "but when they combine with the emotions of graduation, with fast driving and possible alcohol consumption, risks are greatly multiplied. In addition, some of these situations lend themselves easily to fights, vandalism, unnecessary disturbances, and unwanted pregnancies."

Conventions outlining the Safe Grad program are a vital ingredient of success, Mr Yakichuk says. Last year, for example, the convention attracted delegates from about 100 Saskatchewan school divisions, and from as far afield as Whitehorse, Yukon Territories, and the US.

"I'm not aware of anything else in Canada which is running like Safe Grad. There are a couple of schools in Manitoba which have visited us and are now operating awareness programs, and I believe there are also a couple of projects in British Columbia, but these are not aimed specifically at graduation.

"However, there are anything from 50 to 100 spin-off conferences in small Saskatchewan towns and districts, with different tactics in different areas.

"The purpose of the convention is to get the kids excited about what they can do for themselves with help from their parents and interested authorities."

How do students feel about Safe Grad?

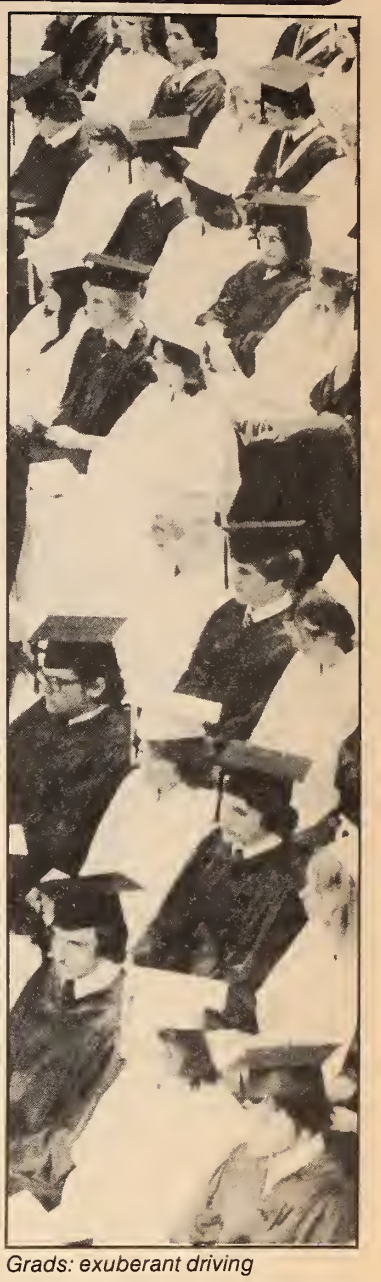
Jackie Sebastian, 17, president of the Miller Student Council told **The Journal**: "Safe Grad goes over really well. It means something. There are lots of students who have parents who drink and who know what it's like, and they have friends who drink a lot. But they also want to save their own and others' lives and they're really into Safe Grad.

"Before, after graduation, we had dances and parties at night and everyone would go out drinking and get loaded. Now parents are there. They don't say 'Don't drink,' but they monitor the drinking and they know where everyone is, and they know no one is driving because we travel in buses.

"Some students say, 'What do we need the parents for?' but that's only about two or three per cent of the whole student population, and they probably don't get along with adults anyway.

"But really, no one is having their fun stopped, and our parents make food and so on and are involved right along with us, and they're celebrating as well. They don't drink, but they're helping us to have a good time. It's great all the way around."

Mr Yakichuk says research reveals several primary areas which should be considered in planning safe celebrations. Some of his suggestions follow:



Grads: exuberant driving

How to plan a safe graduation party

- **Select a party site with a view to avoiding natural hazards, eg, dangerous water, heavy traffic, and so on. Farm animals can also cause problems.**
- **Make provisions for safe transportation to and from celebration sites. Most fatalities occur through car accidents. Especially dangerous are the early morning hours between 5:30 am and 7:30 am.**
- **Ensure that non-drinking drivers are available for all vehicles.**
- **Consider hiring a bus.**
- **Restrict admission to invited students and guests only. Party crashers have caused trouble.**
- **Have adult help available in case gate-crashers do arrive.**
- **Make sure students are aware of the consequences of alcohol and drug abuse; many do not realize how seriously these substances can impair judgement.**
- **Use creative planning to consider alternatives to drugs and alcohol, and discourage their use.**
- **Control drinking via adult supervision.**
- **Consider non-drinkers during planning. About 30% of the student body are non-drinkers, and their wishes also have to be taken into account.**

Grad time is SADD time

NEW YORK — A United States congressman here wants June to be designated national Student Awareness of Drunk Driving Month to help reduce deaths and injuries associated with drunk driving, particularly at graduation time.

New York congressman Ray McGrath says 14 teenagers die each day in the US in alcohol-related accidents. He introduced a resolution to the US Congress in January calling for June to be named SADD Month to focus attention on the prevention of such tragedies.

"June is a month of celebration — graduation and proms," he said. "With such celebrations come the rounds of drinks and the eventual drive home. What better time is there to call attention to the dangers of drunk driving?"

Two groups — Students Against Drunk Driving and Students Against Driving Drunk — have already made in-roads in the US in bringing the message home, he said.

Now he wants to "recognize the efforts of student groups in fighting our drunk driving problem and to encourage the formation of these groups in every area of this country."

For more information: Ray McGrath, 203 Rockaway Ave, Valley Stream, New York, NY 11580.

All professionals should teach public about drugs

FREDERICTON, NB — All professionals who have an influence over large populations should play a positive role in changing public attitudes toward alcohol and drugs, says Everett Chalmers, MD, chairman of New Brunswick's Alcoholism and Drug Dependency Commission (ADDC).

In an address to a service club meeting here, he said all professionals have "a moral responsibility" to deal with addiction problems in their employees, clients, or patients.

"Doctors, nurses, clergy, lawyers, business administrators, teachers, and professors should take a good hard look at themselves and the curriculum of their alma maters," Dr Chalmers said.

About the only thing they learned about alcohol and drugs at the university level was "how to drink and treat a hangover."

Doctors and nurses, said the ADDC chairman, are in the front line when it comes to identifying alcoholism. They treat physical and mental illnesses expertly, but even if they recognize an alcohol problem, too often they do not know what to do for patients.

And this will not change "until governments and the general public put enough pressure on our medical schools to develop an educational program on alcoholism and drug abuse and integrate it into their medical curriculum."

In business, he said, many presidents, executives, and managers of large firms "look upon the liquor cabinet as a mechanism to help business deals and transactions. The liquor cabinet in the office is as common as typewriters or other office equipment."

In his opinion, firms should develop employee assistance programs to help troubled employees.

Members of the clergy have access to a large percentage of the population through their congregations, yet they receive little training in dealing with alcoholism, although Dr Chalmers said he understands change is beginning.

Lawyers involved with matrimonial or criminal practices find alcohol or other drugs play a role in a large percentage of cases. But, they often refuse to get involved in the client's problem.

The same applies to educators, he added. Teachers, principals, and professors, many of them parents, "should be concerned about their own attitudes and those of their students with respect to drinking and drug use."

CAF seeks broader base

HALIFAX — A restructuring of the Canadian Addictions Foundation (CAF) Board will mean broader representation from areas that are related to, but not exclusively concerned with, addictions, says CAF president Ed Fitzpatrick.

"We'll broaden our base so that we're more representative of the many concerns with an interest in addictions," he told **The Journal**. "But at the same time we're maintaining our strong involvement with the provincial commissions; this will give us a little more of what we've been looking for over the past few years."

Elections, including the addition of new board members, are scheduled to be held during the CAF Atlantic Regional Conference in Halifax at the end of the month. The theme will be, 'Families and Drug Dependence — New Problems, New Challenges.'

NB booklet tallies drug stats, facts

FREDERICTON — The New Brunswick Alcohol and Drug Dependency Commission (ADDC) has prepared a 34-page booklet in both English and French providing facts and figures on alcohol and drug abuse.

Produced by the ADDC's Research and Evaluation division, the booklet* outlines the commission's functions and services and includes data on the number of alcoholics in the province, ADDC clientele, and other relevant information.

****Fastats NB III, A Summary of Answers to Frequently Asked Questions* — Alcoholism and Drug Dependency Commission of New Brunswick, Research Division, PO Box 6000, Fredericton, NB E3B 5H1.**

NEWS AND DEPARTMENT

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. For further information, contact Margaret Sheppard at (416) 595-6150.

Drugs and Alcohol: Viable Alternatives

Number: 595.
Subject heading: Attitudes and values, lifestyle, treatment-rehabilitation.
Details: 20 min, 16 mm, color.
Synopsis: An ex-addict talks to a large group of people about ways to feel good instead of using drugs. However, the film points out it is not as easy as it seems. Many things people do are transitory and only relieve boredom for a while. According to the film, we have to know suffering to enjoy what it is to feel good.
General evaluation: Very poor (1.4). The audio-visual review group considered the message unclear, the presentation disjointed, and no real conclusions were reached.
Recommended use: None.

Helping You Help Yourself

Number: 597.
Subject heading: Employee assistance programs (EAPs).
Details: 9½ min, 16 mm, video, color.
Synopsis: Everyone has problems and some cannot be solved alone; EAPs can help. It is important that unions support such policies and make it easier for members to seek help. Several people helped by EAPs are interviewed. They explain the process, and how they felt about it.
General evaluation: Fair (3.1). The review group believed the film was not clear regarding how EAPs actually work, and also that the film's depiction of client confidentiality was simplistic.
Recommended use: With a resource person, it could be used in EAP promotion.

The Troubled Employee

Number: 599.
Subject heading: Employee assistance programs (EAPs).
Details: 28 min, 16 mm, video, color.
Synopsis: This revised version of the film reviewed in **The Journal** in March 1983 has added references to the role of the union. Otherwise it remains the same. Two case studies illustrate that an employee who is having problems outside the workplace will also have trouble at work. These employees contribute to loss of productivity, accidents, and are often late or absent. The film shows how supervisors should handle these employees in the referral interview and also after they are ready to rejoin the staff.
General evaluation: Very good (5.1). With the additional reference to union involvement, this film is an excellent teaching aid for those involved in EAPs.
Recommended use: With a resource person, this film could be of benefit to all those involved in EAPs.

NB commission reorganizes to 'enhance' its services

FREDERICTON — New Brunswick's Alcoholism and Drug Dependency Commission (ADDC) has been reorganized to consolidate its operations into three new divisions.

ADDC chairman Everett Chalmers, MD, said he expects the changes, announced in February, to enhance the delivery of services to the public.

The ADDC will now have a senior management team comprising the directors of the new divisions, together with executive director Ed Thomas and Dr Chalmers. Policy will, however, remain the responsibility of the 10 regional commission members.

The new divisions are:

- community services division, taking in the former employee assistance programs division, the justice intervention division, the education and prevention division, and the women's programs division. Director is D. Achille Maillet;
- support services division, bringing together the former research, information, personnel, payroll, and finance sections, under director Wayne Weagle; and,
- the treatment and rehabilitation division remains, but with Joseph MacIntyre as its new director. Assistant director is Ronald McHugh.

NEWS AND DEPARTMENT

'Intense' Canadian campaign to follow US launch

Guide helps druggists help parents

TORONTO — The Ontario Pharmacists' Association and the Council on Drug Abuse (CODA) are launching what they hope is the spearhead of a national campaign to tell parents about drug and alcohol addiction.

The campaign was officially started at the CODA's 15th anniversary dinner here in February. Murray Koffler, honorary chairman and CODA founder, said the project coincided with a similar program in the United States.

Pharmacists, drug manufacturers, and guests were shown a television tape of the US launch, led by US first lady Nancy Reagan and television actor Michael Landon. The two made emotional appeals for support from druggists.

Said Mr Koffler: "This is the start of a very intense television campaign. We're cooperating with the US producers, and we're going to have our own Canadian commercial related to our own environment.

"There are going to be 17 Ontario TV stations involved in delivering the message, and 91 radio stations, backed by an aggressive publicity campaign in all Ontario newspapers, large and small, as well as magazines and the electronic media."

Central to the project is a guide book and pamphlets bearing the logo, PADA — Pharmacists Against Drug Abuse. Funding for the production and design of the booklet and handouts came from pharmaceutical manufacturers.

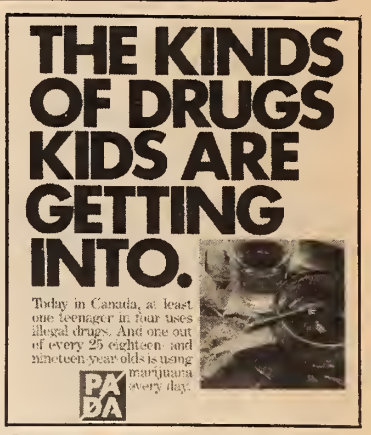
The guide book aims to provide druggists with up-to-date information on a wide range of drugs to enable them to help parents.

Pharmacists will also be given PADA lapel badges, identifying their involvement with the program.

"The public always go to private pharmacists," said Mr Koffler. "You don't have to make an appointment. All the parents have to do is visit the nearest drug store, pick up a free pamphlet, and ask their pharmacist for advice. The pamphlet isn't really for kids; it's directed at their parents."

Mr Koffler also mentioned PAD — Parents Against Drugs — which recently started in Toronto and is now Ontario-wide.

"This group is working its way through Ontario schools because there are some people who don't want to go to their pharmacist, who won't go to their doctor or to the police," he said. "But they can go to other parents who share the problem."



Pamphlet: no appointment

The CODA also used the anniversary dinner to honor Norman Panzica, an author and consultant with the CODA on drug abuse problems. Mr Koffler said Mr Panzica had been associated with the CODA for 23 years.

New Books

by RON HALL

Ontario Juvenile Delinquency Statistics and Their Implication for Drug Education Programming

. . . Simmie C. Magid and Michael S. Goodstadt

This working paper presents statistics on detected and reported juvenile delinquency in Ontario. Data cover the years 1978 to 1981. The authors indicate that although there is a need to explore further the relationship between drug and alcohol use and criminality among juveniles, young people in trouble with the law would seem to be an obvious target for educational programs on substance use and abuse. The following questions are posed: How many such juveniles are there? Where can they be found? How long will they be there? Where will they go next? Statistical tables are presented by the authors with the aim of finding answers to these questions, to the extent that they are answerable by statistics. Sections are devoted to police statistics, court statistics, drug, and alcohol-related charges, and corrections statistics.

(Addiction Research Foundation, Marketing Services, Dept JR, 33 Russell St, Toronto, ON M5S 2S1. 1983. 73 p. $7.50 ISBN 0-88868-079-1)

Alcoholism, Narcissism and Psychopathology

. . . by Gary G. Forrest

This book is devoted to an in-depth consideration of the psychopathology of alcoholism. Each chapter focuses upon a different clinical aspect of the alcoholic adjustment style; yet, the data in each chapter are integrated and synthesized. The author delineates how narcissistic injury in early life acts as the basic psychogenic, etiological component of alcoholism. Discussions examine the pathologies of character, personality, behavior, cognition, and interpersonal relationships that manifest themselves in and as alcoholism. The author includes guidelines and strategies for treatment that are designed to modify and resolve the alcoholic patient's pathologic symptoms. The material presented in the book has been derived from clinical work with chronic alcoholics. The clinical case studies presented are "typical" from the perspective of the author's psychotherapy experiences with alcoholics. This book is written for the professional behavioral scientist. Other professionals who work with alcoholics will find the book to be useful.

(Charles C. Thomas, Publisher, 2600 S 1st St, Springfield, IL 62717. 1983. 308 p. $28.50. ISBN 0-398-04815-0)

Other books

Substance Abuse Book Review Index 1982 — Bemko, Jane. Addiction Research Foundation, Toronto, 1983. Citations of 228 monographs; source information on reviews of these monographs; indexes. 57p. Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1 $6.95. ISBN 0-88868-083-X.

Older Adults: A Unique Population at High Risk for Alcohol and Drug Abuse Problems — Opstelten, George E. Aging/Alcoholism Information Committee, Daly City, 1982. Growing old in America; facts about alcohol; mixing alcohol with medications; recovery; future strategies for the older adult with alcohol and substance abuse problems. 69 p. Aging/Alcoholism Information Committee, PO Box 3053, Daly City, CA 94105-0053. $3.95.

DEPARTMENT

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Canadian Association of Addiction Counsellors 5th Annual Conference — Lifestyle — April 7, Toronto, Ontario. Information: Roberta Clark or Bill Vine, Nightingale Campus, George Brown College, 2 Murray St, Toronto, ON M5T 2T9.

American Orthopsychiatric Association 61st Annual Meeting — April 7-11, Toronto, Ontario. Information: The American Orthopsychiatric Association, 19 W 44th St, Ste 1616, New York, NY 10036.

Research 84: Understanding the Nature of Nursing through Research — April 13, Toronto, Ontario. Information: Rose Antonio, Continuing Education Program, University of Toronto, Faculty of Nursing, 50 St George St, Toronto, ON M5S 1A1.

Public Drinking and Public Policy: A Symposium on Observation Studies — April 26-28, Banff, Alberta. Information: Eric Single, Addiction Research Foundation, (ARF), 33 Russell St, Toronto, ON M5S 2S1.

1984 Canadian Addictions Foundation Atlantic Regional Conference, Families and Drug Dependencies New Problems, New Challenges — April 29-May 3, Halifax, Nova Scotia. Information: Nova Scotia Commission on Drug Dependency, Ste 314, Lord Nelson Bldg, 5675 Spring Garden Rd, Halifax, NS B3J 1H1.

Detox Training Program (Non-Medical) — April 30-May 4, Toronto, Ontario. Information: Diane Hobbs, Detox and Rehab Programs, ARF, 33 Russell St, Toronto, ON M5S 2S1.

Addictions Extravaganza — May 5-6, Regina, Saskatchewan. Information: Lorri Hovland, Addictions Ex, 728 Broad St N, Regina, SK S4R 7B5.

Introductory Addictions Management Course — May 14-16, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

The 6th Institute of the Section on Women and Psychology (SWAP) of the Canadian Psychological Association — May 30, Ottawa, Ontario. Information: Dr Katherine Schultz, department of Psychology, University of Winnipeg, 515 Portage Ave, Winnipeg, Manitoba, R3B 2E9.

Canadian Psychological Association Conference — May 30-June 2, Ottawa, Ontario. Information: Dr Katherine Schultz, department of Psychology, University of Winnipeg, 515 Portage Ave, Winnipeg, Manitoba R3B 2E9.

Alcohol, Other Drugs and the Law Course — June 4-6, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Impact 84, The Citizen and the Criminal Justice System — An International Seminar — June 17-21, Toronto, Ontario. Information: R.E. Fox, Ste 214, 75 Lemonwood Dr, Islington, ON M9A 4L3.

Canada Safety Council 16th Annual Safety Conference — June 24-27, Ottawa, Ontario. Information: Canada Safety Council, 1765 St Laurent Blvd, Ottawa, ON K1G 3V4.

25th Annual Institute on Addiction Studies — July 15-20, Hamilton, Ontario. Information: Karl N. Burden, Course Director, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

Summer Fundamental Concepts Course — July 16-19, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Medical Women's International Association 60th Congress: Men and Women, Biological and Behavioral Differences — July 29-Aug 4, Vancouver, British Columbia. Information: Congress Secretariat, Medical Women's International Association, #1704-1200 Aberni St, Vancouver, BC V6E 1A6.

Annual Convention of the American Psychological Association — Aug 24-28, Toronto, Ontario. Information: American Psychological Association, 1200 17th St, NW, Washington, DC 20036.

University of Toronto Department of Psychiatry 10th Annual Research Day — Sept 14, Toronto, Ontario. Information: K. Drysdale, Secretary, Research Fund Committee, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Workplace 84 "Making the Most of Human Potential" — An Employee Assistance Programming Conference — Oct 15-17, Grande Prairie, Alberta. Information: Iyas Abbas, Alberta Alcoholism and Drug Abuse Commission, Provincial Bldg, Rm 2204, 10320 99th St, Grande Prairie, AB T8V 6J4.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-9, 1985, Calgary, Alberta. Information: Jan Skirrow, Chairman, 34th ICAA Congress, AADAC, 6th fl, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

United States

Counselling for Prevention Relapse — April 5-6, Dallas, Texas. Information: Cana Powell, The Addiction Treatment Center, PO Box 669, Bedford TX 76021.

3rd Annual Symposium on Chemical Dependency — April 6-7, Boise, Idaho. Information: Tim Kelly, Walker ACT Center, PO Box 541, Gooding, ID 83330.

Understanding the Systems and Working Together: The Courts and Substance Abuse Services — April 9-10, Kalamazoo, Michigan. Information: Sally J. Myers, MAAA Administrative Assistant, Michigan Alcohol and Addiction Association, 21711 W Ten Mile Rd, Southfield, MI 48075.

Western Regional ALMACA Conference — April 11-13, Los Angeles, California. Information: Jack Rose, Conference Chair, Lockheed-California Company, Employee Assistance Program, PO Box 551, Burbank CA 91520.

Ruth Fox Course for Physicians — April 12, 1984, Detroit, Michigan. Information: Claire Osman, Course Coordinator, American Medical Society on Alcoholism, 733 3rd Ave, New York, NY 10017.

15th Annual Medical-Scientific Conference of the National Alcoholism Forum, "Clinical Applications of Alcoholism Research" April 12-15, Detroit, Michigan. Information: Medical-Scientific Conference Coordinator, AMSA, 733 3rd Ave, 14th fl, New York, NY 10017.

National Alcoholism Forum of the National Council on Alcoholism — April 12-15, Detroit, Michigan. Information: Angela Masters, 733 3rd Ave, New York, NY 10017.

5th Regional Conference on Substance Abuse "Innovations in Prevention and Treatment" — April 18-20, Cincinnati, Ohio. Information: Ann Blankenhorn, Central Community Health Board, 532 Maxwell Ave, Cincinnati, OH 45219.

66th American Assembly on Public Policy on Alcohol Problems — April 26-29, Harriman, New York. Information: The American Assembly, Columbia University, New York, NY 10027.

National Conference for Youth on Drinking and Driving — April 27-30, Chevy Chase, Maryland. Information: Secretarial Initiative on Teenage Alcohol Abuse, Room 12C - 26, Parklawn Bldg, 5600 Fishers Ln, Rockville, MD 20857.

Alcoholism and Family Violence — May 7-8, Honolulu, Hawaii. Information: Ysaye M. Barnwell, Division of Child Protection, Children's Hospital National Medical Center, 111 Michigan Ave, NW, Washington, DC.

Why It Works: An Appreciation of Alcoholics Anonymous — May 11, Milwaukee, Wisconsin. Information: Candee Brandis, Training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

Annual Meeting of the National Association of Alcoholism Treatment Programs — May 14-17, Denver, Colorado. Information: Vicki Kotecki, NAATP Manager, Administrative Services, 2082 Michelson Dr, Ste 200, Irvine, California 92715.

3rd Annual Seminar on "Chemical Dependency: Issues in Treatment" — May 18-19, Asheville, North Carolina. Information: Jerry Bryson, Woodhill Drug and Alcohol Treatment Center, Appalachian Hall, PO Box 5534, Asheville, NC 28813.

Annual Conference of the Association of Halfway House Alcoholism Programs of North America — May 20-23, Santa Monica, California. Information: AHHAP, 7786 E 7th St, Minneapolis, Minnesota, 55106.

National Conference on Women and Alcoholism — May 23-25, Seattle, Washington. Information: Dr Geri Marr Burdman, department Community Health Care Systems SM-24, University of Washington, Seattle, WA 98195.

3rd Annual National Conference on Alcoholism and the Family — May 23-27 — Philadelphia, Pennsylvania. Information: Mike Woodnick, The Caron Foundation, Box 277, Wernersville, PA 19565.

Denial in Alcoholism and Chemical Dependency: An Advanced Course in Identification and Management — May 25, Baltimore, Maryland. Information: Gloria Uhl, Health Education Council, 7201 Rossville Blvd, Baltimore, MD 21237.

"Creative Alliance — Progressing with Precision" — June 1-3, Traverse City, Michigan. Information: Sally J. Myers, MAAA Administrative Assistant, Michigan Alcohol and Addiction Association, 21711 W Ten Mile Rd, Ste 105, Southfield, MI 48075.

46th Annual Scientific Meeting of the Committee on Problems of Drug Dependence — June 4-6, St Louis, Missouri. Information: Dr Joseph Cochin, department of Pharmacology, Boston University, School of Medicine, 80 E Concord St, Boston, Massachusetts 02118.

5th Annual National Conference on Employee Assistance Programming — June 4-7, Kansas City, Kansas. Information: Bethany Medical Center, The EAP Conference, 51 N 12th St, Kansas City, KS 66102.

North American Conference on Alcohol and Highway Safety — June 12-14, Baltimore, Maryland. Information: Dr Patricia Santora, Program Director, Johns Hopkins University School of Medicine, 57 Turner Auditorium, 720 Rutland Ave, Baltimore, MD 21205.

33rd Annual Session University of Utah School on Alcoholism and Other Drug Dependencies — June 17-22, Salt Lake City, Utah. Information: University of Utah School on Alcoholism and Other Drug Dependencies, PO Box 2604, Salt Lake City, UT 84110.

35th Annual Symposium on Alcoholism — June 18-29, Seattle, Washington. Information: Alcohol Studies Program, Seattle University, Seattle, WA 98122.

Cocaine Dependence — Assessment and Treatment — July 13-14, Chicago, Illinois. Information: Terry Dunivin, Clinical Training and Education Associates, 1130 Hill St, Ann Arbor, Michigan, 48104.

National Association of Alcoholism and Drug Abuse Counsellors' Annual Conference — Aug 4-8, Indianapolis, Indiana. Information: NAADAC, 951 S George Mason Dr, Arlington, Virginia 22204.

The International Doctors in Alcoholics Anonymous Annual Meeting — Aug 9-12, Minneapolis, Minnesota. Information: Dr Lewis Reed, Information Secretary, IDAA, 1950 Volney Rd, Youngstown, Ohio 44511.

North American Congress on Employee Assistance Programs — Aug 12-15, Dearborn, Michigan. Information: Diane Vella, Congress Coordinator, NAC/EAP, 2145 Crooks Rd, Ste 103, Troy, MI 48084.

7th Annual School for Alcohol and Drug Studies — Aug 12-17, Wilmington, North Carolina. Information: North Carolina School for Alcohol and Drug Studies, Office of Special Programs, UNC-Wilmington, 601 S College Rd, Wilmington, NC 28403-3297.

Alcohol and Drug Problems Association (ADPA) 35th Annual Conference — Aug 19-23, Washington, D.C. Information: Eric Scharf, Alcohol and Drug Problems Association, 1101 15th St, NW, #204, Washington, DC 20005.

Abroad

6th International Conference on Alcohol-Related Problems — April 8-13, Liverpool, England. Information: Conference Secretary, MLCCA, 1st fl, The Fruit Exchange, Victoria St, Liverpool L2 6QU, England.

14th International Institute on the Prevention and Treatment of Drug Dependence — May 27-June 2, Athens, Greece. Information: International Council on Alcohol and Addictions (ICAA), Case postale 140, 1001 Lausanne, Switzerland.

30th International Institute on the Prevention and Treatment of Alcoholism and 14th International Institute on the Prevention and Treatment of Drug Dependency — Athens, Greece, May 27-June 2, 1984. Information: ICAA, Case postale 140, 1001 Lausanne, Switzerland.

Families with Alcohol Problems: Models of Intervention — June 26-29, Dublin, Ireland. Information: Monica McGoldrick, Family Training Program, UMDNJ-RMS-CMHC, Piscataway, New Jersey 08854.

3rd Biennial American University School of Justice Institute on Juvenile Justice — July 8-July 27, London, England. Information: Professor Richard A. Myren, Director, Institute on Juvenile Justice in England and America, School of Justice, The American University, Washington, DC 20016.

4th World Congress of Alternative Medicine — July 13-15, 1984, Amsterdam, the Netherlands. Information: Prof Dr Anton Jayasuriya, Secretary Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

International Narcotic Research Conference — July 22-27, Cambridge, England. Information: Linda Byford, Parke Davis Research Unit, Addenbrookes Hospital Site, Cambridge CB2 2QB, England.

3rd International Conference on Treatment of Addictive Behaviors — Aug 12-16, North Berwick (Edinburgh), Scotland. Information: William R. Miller, department of Psychology, University of New Mexico, Albuquerque, New Mexico 87131.

5th World Congress on Prevention — Aug 26-30, Rio de Janeiro, Brazil. Information: Ernest H. J. Steed, Executive Director, International Commission for the Prevention of Alcoholism and Drug Dependency, 6830 Laurel St, NW, Washington DC 20012.

12th International Conference on Health Education — Sept 1-6, 1985, Dublin, Ireland. Information: Dr H. D. Crawley, Director, Health Education Bureau, 34 Upper Mount St, Dublin, Ireland.

Seminar on Addiction — Sept 6-14, Athens, Greece. Information: Darcy Edwards, Millglen Medical Corp, PO Box 888673, Atlanta, Georgia 30356-0673.

8th World Conference of Therapeutic Communities — Sept 2-7, Rome, Italy. Information: Charles J. Devlin, Executive Director, Daytop Village Inc, 54 W 40th St, New York, NY 10018.

International Congress on Alcohol Dependence, The Family and The Community — Sept 16-22, Jerusalem, Israel. Information: International Congress on Alcohol Dependence, the Family and the Community, Kenness International Inc, 1 Park Ave, New York, NY 10017.

11th International Conference of Social Gerontology — Oct 16-19, Rome, Italy. Information: International Center of Social Gerontology, 91, rue Jouffroy, 75017 Paris, France.

2nd Inter-American Symposium on Health Education — Nov 4-9, Acapulco, Mexico. Information: Symposium Steering Committee, c/o NARO, PO Box 2305, St "D", Ottawa, Ontario, K1P 5K0.

The Vancouver system

Addicted mothers and babies

By Tim Padmore

VANCOUVER — There's something not right about baby Richard.

He's fretful and hardly seems to sleep. His tiny cries are bitter and angry.

It's hard for him to keep down his formula, and he is plagued with diarrhea. He also sneezes and has cold sweats.

Richard might have a brain infection — it wouldn't be the first time a baby like this has been misdiagnosed as having meningitis — but what Richard is actually suffering from is narcotic withdrawal.

Doctors know of about two dozen babies a year born addicted to narcotics in Vancouver. It's a problem seen in such United States cities as New York and San Francisco, but less frequently in Canada, says pediatrician Sydney Segal, a professor in the University of British Columbia faculty of medicine.

Dr Segal and others at three cooperating Vancouver hospitals have come up with an innovative approach to managing these babies through their withdrawal crises and protecting them from hazards that can follow them all their lives.

It's a tough medical problem, complicated by legal, political, and social issues.

Dr Segal, an authority on infants of narcotic addicts (INAs), has been struggling with the problem for close to 20 years.

In a recent interview with **The Journal**, he sketched what he and others have learned.

Traditional magic

Even for narcotics addicts, the prospect of motherhood works some of its traditional magic, says Dr Segal.

"Ordinarily, they are like other addicts — anti-social and not caring who they step on. But when they are pregnant, they become very guilt-ridden and want to do everything they can for the baby."

They often ask the doctor to help them withdraw, but the answer almost always has to be, "no."

That's because the trauma and stress of withdrawal can easily cause the baby's death, Dr Segal says. The fetus, sharing in the stress of withdrawal, can suffer brain damage from lack of oxygen.

Although there is debate on the question, Dr Segal considers withdrawal safe for the fetus during the first three months of pregnancy.

However, he says addicts rarely discover they are pregnant that early because their menstrual cycles are usually disrupted by drug abuse, their pregnancies unplanned, and their physical conditions poor. So pregnancy is not suspected until it is too late for either abortion or withdrawal.

A basic problem at this stage is how to schedule narcotic maintenance.

About three years ago, Dr Bernd Wittmann at Grace (obstetrics) Hospital here started ultrasound examinations of pregnant addicts who were being maintained on the usual one-dose-a-day regime.

An observer counted fetal hiccups and body movements, and recorded the number and length of breathing patterns for one hour.

"Within an hour or so of the administration of methadone, fetal activity decreases sharply," Dr Wittmann told **The Journal**. "But just before administration, the fetus appears to be very active."

The conclusion was that the fetus was undergoing partial withdrawal once a day.

The doctors found, however, that simply splitting daily doses into two half-doses, administered 12 hours apart, usually resulted in normal fetal activity profiles.

Segal: we don't let our babies go through any agony that we're aware of

(The ultrasound work is described in the proceedings of the International Symposium on Fetal Activity, London, Ontario, 1982. A discussion of the overall management of neonatal withdrawal can be found in the December 1983 issue of *Pediatrics*.)

The split-dosage schedule can be a difficult one for the addict, if she has to make two trips a day to the provincial methadone clinic.

Double agent

So, William Young, MD, who runs the provincial methadone programs, agreed that, when indicated, he would bend the clinic's rule against methadone "carries" and allow a pregnant addict to take her second dose away with her.

Addicts who are not already on a methadone program are permitted to join, said Dr Young.

"We put them on a dose of methadone that's as low as possible. After delivery, they can go on the methadone stabilization program," (a time-limited program of methadone maintenance — See BC, page 2).

If the mother indicates she wants to give up her baby for adoption, the department of human resources begins planning for an adoption. If it appears she will want to keep it, doctors and nurses begin an evaluation of her fitness to manage a difficult baby.

It is the start for the health professionals of what Dr Segal calls a "double agent" role.

"They have trusted me. They come with their boyfriends — who're often drug vendors who talk with the air of pharmacy professors," he says.

"You're a double agent; you try to support them, and you have to be ready to kick them into the courtroom."

After the birth, comes the big medical challenge, explains Dr Segal.

The baby is transferred from Grace Hospital to next-door Children's Hospital. Within a few hours, or days, the baby starts showing symptoms of withdrawal: colic, diarrhea, vomiting, episodes of arrested breathing, erratic heartbeat, sleeplessness, unstable body temperature, weight loss, irritability, tremors, crying, sneezing, rapid breathing, and sweating.

Unwatched and untreated, the infant can die — of dehydration, for example, or shock from severe diarrhea.

Another danger is that the symptoms of withdrawal can mask other serious illnesses, like pneumonia, meningitis, or generalized infection.

Stacking the deck against the narcotic-addicted infant, the mother may also be in poor shape at the time of delivery — undernourished or intoxicated. One woman for instance, drank a whole bottle of rye whiskey when labor started, says Dr. Segal.

Kept in the dark

Light and sound can also be extremely painful, so the infant is kept in dark, quiet areas, first, in the acute section of the Children's Hospital special care nursery, then in the growers' nursery, and, finally, after its condition is stabilized, in a room at Sunny Hill Hospital, a hospital for handicapped children.

An infant undergoing withdrawal burns up almost three times as many calories as a normal baby. Because there is a limit to stomach capacity, a special high-calorie formula is used, and feelings are coordinated with medication to avoid loss of nourishment through vomiting.

Ideally, withdrawal is accomplished without opiates.

"We don't let our babies go through any agony that we're aware of," says Dr Segal, "but we're not quick to start opiates, because it prolongs the baby's stay in hospital a great deal."

Paregoric is the traditional choice, but in Vancouver it has been rejected because of its relatively high alcohol content and the fact it contains toxic camphor and anise oil.

Instead, nurses administer carefully titrated doses of tincture of opium diluted 25 times with water. This has worked so well that the preparation may soon be recognized by others as standard, says Dr Segal.

Phenobarbitol is often useful when non-opiate drugs are involved, but not for opiate withdrawal, because it doesn't cure gut spasms or prevent convulsions. Withdrawal from Talwin (pentazocine), a drug seen with frequency in the Vancouver area (**The Journal**, Dec 1983), is especially hard to manage, says Dr Segal.

(The Vancouver team has written a detailed INAs nursing care plan, which will be released soon through the Children's Hospital administration.)

At Sunny Hill, the children are finally weaned from opium.

The INAs are among the few acute-care patients there. But personnel are trained in infant stimulation and in evaluating and heading off long-term developmental problems. (See Research Update, page 4)

Agonizing challenge

INAs suffer a 10 times greater than normal incidence of sudden infant death syndrome in the first year. Exposure to narcotics reduces their natural immunity to infection. Many will have long-term problems, says Dr Segal, including short attention spans, learning disabilities, motor problems, delayed speech development, and difficulty making friends.

"The other 50%," he says, "seem to emerge indistinguishable from other kids, whether the child is raised within the drug subculture or in a foster home."

However, there is another major hazard for INAs raised by parents who are part of the drug subculture — child abuse. The babies are particularly vulnerable because they are prone to inconsolable crying.

Caring for such infants is an "agonizing challenge," even for professional nurses, says Dr Segal. A mother pre-occupied with her own need for drugs, or with a short-tempered boyfriend, is too easily tempted to try to end the crying by abusing the child.

When the mother is determined to keep her child, she is encouraged to help in caring for it, even in the special care nursery, because early contact is important to establish maternal bonding. She is taught parenting skills and is observed in an effort to evaluate the likely quality of the home she will provide.

Potential foster homes are screened carefully as well. One requirement is no smoking, because INAs are prone to respiratory infections.

When the mother does take custody, it is generally with an agreement to accept support from a homemaker and social worker.

Mothers do still lose custody of their children.

The most highly-publicized failure was that of a little girl known only as DJ, born December 10, 1981, to a non-status Indian woman, now 25, who has been addicted to narcotics since she was 12. In May, 1982, the baby was taken into custody by the authorities. (Story page 1)

But the program can work too.

Miranda, two, and Adam, one, were born addicted to methadone. Today, the two blonde, bouncy children play with their toys in a small East End apartment. Of their mother, who remains on a twice-a-week methadone support program, they demand only to be hugged "a hundred times a day."

*References are available on written request from **The Journal**, 33 Russell St, Toronto, Canada M5S 2S1.*

THE BACK PAGE

Coca paste: a 'burgeoning disaster' p7

Trebach: Heroin and pain relief p5

Terris: Beyond the Lalonde Report p9

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The Journal

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Coca paste alarm sounded by Bolivian expert

By Harvey McConnell

ATLANTA — Large-scale importation of coca paste into North America is a distinct possibility and will produce devastating problems if it happens.

This is the stark warning given to **The Journal** by Nils Noya, a leading expert on cocaine addiction, who is director of rehabilitation and prevention services in Santa Cruz, Bolivia.

"I hope I am wrong, and I know officials here are more optimistic, but I don't think I am," he said.

Smoking coca paste (the first product of the extraction from the coca bush leaf) is now endemic in Peru and Bolivia and spreading across the continent. Current North American problems with cocaine hydrochloride (the white powder refined from the paste) pale by comparison. (See — Coca — page 7)

The "insurmountable problems" associated with coca paste addiction were outlined here by Dr Noya and Raul Jéri, neuropsychiatric consultant to the Peruvian ministry of the interior, at the international PRIDE conference for parents and youth.

Dr Noya, whose warnings about cocaine's addictive potential were first reported in **The Journal** in 1978, and, at the time, generally ignored by the substance abuse field in North America, says: "People in the United States and Canada must understand that cocaine sulphate (coca paste) is far more dangerous and far more addictive than cocaine hydrochloride.

"And they must realize the chances of curing a cocaine sulphate addict are almost nil. I mean nil. For heroin addiction there are substitute drugs; for cocaine addiction there are no means to fight against it."

Exporting coca paste to North America by Bolivian traffickers — bypassing the expensive conversion to cocaine hydrochloride in Colombian laboratories — is a logical step, says Dr Noya.

"If they can get a cheaper drug to sell here, they can hook a lot more people, which is good business. Why shouldn't they do it?"

Coca paste, unlike cocaine powder, has a distinctive aroma. "Don't worry," Dr Noya adds, "the traffickers will find a way to disguise the smell. We know coca paste has been shipped to California in tubes inserted in bottles of shampoo."

Coca paste smoking has spread from Bolivia and Peru to Colombia, Ecuador, Brazil, and Argentina. "We know a lot of coca paste is being smuggled into Argentina because I am being asked by psychiatrists in Buenos Aires what to do with the addicts they are now seeing there."

The market will grow even larger if reports are correct that the coca bush is now being cultivated in the Mato Grosso area of Brazil. Dr Noya comments: "It is a beautiful area for coca bush production, and it may be that the Brazilians will try to do it the Brazilian way — o *mies grando mundo* — the biggest in the world."

Noya: not optimistic

Jéri: money for weapons

Dr Jéri says small but dedicated revolutionary bands in Peru, Ecuador, and Colombia have become involved in cocaine trafficking. "The coca-people give them money for weapons, and, with the weapons, the terrorists protect the coca-people. There is a tremendous amount of violence and murder," he says

Coca paste is being mixed with marijuana by addicts in Colombia — although not in the rest of South America as yet — and the potentiating effects of the combination produce random homicidal aggression akin to that seen among chronic PCP (phencyclidine) abusers in the US, Dr Jéri notes.

Indians in Peru, Bolivia, and Ecuador "start chewing coca leaves when they are a young boy or girl, and chew until the day they die," but they don't use cocaine. In Colombia, however, there is no history of coca-leaf chewing among the Indians, and Dr Jéri says there are stories they are now being given coca paste by hacienda owners to increase their capacity to work.

A few years ago, the majority of coca paste smokers started their

(See — Coca — page 2)

Pharmacists remove inhaler from shelves

Benzedrex abuse reports are surfacing

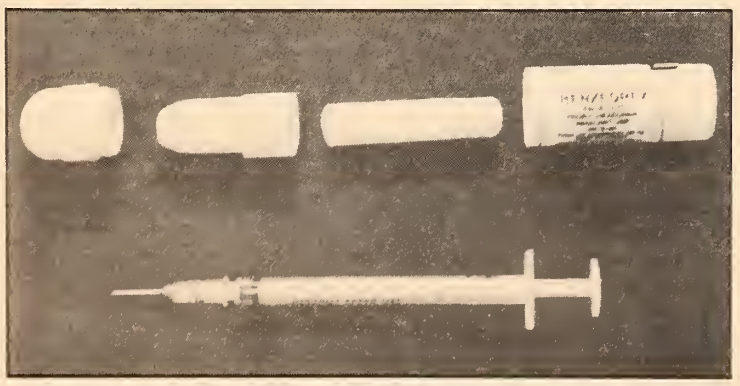
By Jon Newton

TORONTO — Individual action by Canadian pharmacists may well have helped to hold back widespread abuse of Benzedrex, a nasal decongestant inhaler.

At least 20 deaths in Dallas, Texas, have already been attributed to injected propylhexedrine (PPH), the active ingredient in Benzedrex, which is manufactured for over-the-counter sale in Canada by Toronto's Smith, Kline and French (SK&F).

Addiction Research Foundation (ARF) neurologist Luis Fornazzari, MD, has seen three patients here so far this year presenting with Benzedrex abuse symptoms, including some brought on by a bizarre method of injection.

They were "fixing" home-made PPH preparations called "stove-top speed" directly into their jugular veins, causing brain damage, deadening of some cranial nerves leading to facial numbness and temporary paralysis, and a transient loss of ability to move the eyes.



Dismantled inhaler: cotton filler holds offending substance

A fourth patient died of complications following long-term amphetamine and Benzedrex addiction.

Benzedrex was introduced to the pharmaceutical market in 1949 as a "safe" alternative to amphetamine-based Benzedrine inhalers, introduced by SK&F in 1932.

Incidences of PPH psychosis — similar to schizoid-like behavior brought on by amphetamine abuse — began to appear in the early 1970s. Between 1973 and 1979, 15 PPH-related deaths were reported by researchers in Dallas, led by Ron Anderson, MD.

Dr Anderson told **The Journal** that 13 of the victims were young, black men, and two were young, black women. All were addicted to Benzedrex for periods ranging from months to many years. Some were injecting Benzedrex preparations, while others swallowed the cotton fillers. However, he said none of the addicts seen by him injected into neck veins.

Dr Anderson believes these victims represent the "tip of an iceberg" and that Benzedrex abuse is probably far more widespread than realized by professionals.

This view is upheld by the experience of some Canadian pharmacists who have been seeing thefts of Benzedrex from their counters for years.

As one drug store owner told **The Journal**: "Youngsters were coming in and stealing the inhalers, or trying to buy handfuls. They were obviously not being used to alleviate colds, and I decided to stop selling them altogether."

The Journal spoke to 16 pharmacists from two major drug chains in downtown and suburban Toronto. They were chosen at random. All but one had made an independent decision either to withdraw the inhalers altogether, or to restrict sales to behind the counter.

Spokesmen for both drug chains praised the action by their chemists and said they would now be advising all associated stores across the country to make sure other pharmacists are aware of the danger.

Druggists in the United States also acted independently to remove the inhalers from general sale, an effective indication of the seriousness of the problem, said Dr Anderson.

Moreover, he believes that while Benzedrex abuse is at the moment endemic, it could easily become

(See — PPH — page 2)

Canada's system at risk

Health care is ailing

TORONTO — Canada's health insurance system is in jeopardy and the risk is being underestimated by public health workers, says Milton Terris, MD, one of North America's leading public health experts.

Dr Terris says "conservative and reactionary forces" undermined Britain's National Health Service and could soon destroy 50 years of public health program development in the United States. And Canada could be next, he says in Newer Perspectives on the Health of Canadians: Beyond the Lalonde Report — page 9.

INSIDE

NEWS

Briefly . . .

Weight hazard

PRINCETON, NJ — Researchers here and in Venezuela warn that high doses of amphetamines over a short period of time may spark overeating and weight gain. A study, reported in *The Journal of Pharmacology and Experimental Therapeutics*, linked changes in the metabolism of laboratory rats to amphetamine interaction with catecholamines in the brain. High doses of amphetamine injected into the lateral hypothalamus led to temporary anorexia, followed by chronic overeating and obesity.

Snorting danger

STONY BROOK, NY — Two cases of subarachnoid hemorrhage within minutes of snorting cocaine have been reported in *Medical News* (March 1). Two women experienced sudden, severe headaches, coupled in one instance with nausea and vomiting, and in the other with momentary alteration of consciousness, neck pains, and photophobia. The study team advise doctors to bear in mind the possibility of hemorrhage when they see patients complaining of headaches following cocaine use.

Tobacco sachet ban?

LONDON — ASH (Action on Smoking and Health) has called on European health ministers to ban the introduction of tobacco sachets because of the risk of cancers on the lining of the cheek and gum. The sachets, called Skoal Bandits, are held between the lip and the gum, and are said to provide oral nicotine without the dangers of lung cancer. In a March 22 article in *Doctor*, however, ASH director David Simpson cautioned that cancer risks may nonetheless be similar to those of tobacco chewing.

Gambler loses

TORONTO— A banker's addiction to gambling, which began with bets at horse races when he was 13, has landed him a six-year jail sentence. His $10.2 million spree at Atlantic City gambling tables, with money stolen from his bank, was termed an addiction in court. One social worker said: "For him it was the rush, the thrill, the ecstacy of victory and being a high roller."

On the radio

WASHINGTON — June 1 is the planned kick-off day for a 14-week, national radio program aimed at fighting school-age drug abuse. Sponsored by Kiwanis International, a community service organization, the program will feature United States First Lady Nancy Reagan.

Unhealthy teen habit

LONDON — Teens who smoke lose their health rapidly, say doctors at Charing Cross Hospital Medical School here. After two years of smoking more than a few cigarettes a day, the teens studied appeared less healthy and showed evidence of early obstruction of the airways. The study followed 450, 13-year-old students at two London schools between 1975 and 1979, the *British Journal of Medicine* (March 23) reports.

We're on down-side of the slope, says Turner

Traffickers trading cocaine for pot

By Harvey McConnell

ATLANTA — Some drug traffickers in the United States are now trading cocaine for marijuana among themselves.

And recent arrests in Florida and Mississippi of dealers making such trades raises an intriguing question, believes Carlton Turner, PhD, director of the White House Office on Drug Abuse Policy.

"Why are dope dealers willing to trade a commodity which is supposedly the most reinforcing drug known to man, and for which there is supposedly an insatiable demand out there, for a product that is supposedly not as reinforcing, or not supposed to create an insatiable desire?

"I think it tells me something we are not picking up on our survey: that the demand for cocaine has peaked. I think we are on the down-side slope. Certainly there has been a reduction in cost of cocaine."

This does not mean "you are not going to find places where cocaine is still very hot," Dr Turner says but, again, it raises the question: "why would there be a decrease in cocaine prices and why would someone want to trade cocaine for marijuana if there is a continuous increase in demand?"

Dr Turner, who was attending the international PRIDE parents conference here, said the government hopes to have by August an environmental impact statement on domestic eradication of marijuana.

He said: "Whatever that environmental impact statement tells us we ought to do, we certainly are going to do it. If it is the herbicide paraquat they recommend, then we're going to use it. If it is another herbicide, like 2,4-D, we are going to use it."

Spraying of marijuana crops grown on federal forest land was interrupted last summer when the National Organization for the Reform of Marijuana Laws and other groups got injunctions prohibiting further spraying until an environmental impact statement was obtained.

Dr Turner told the PRIDE delegates that marijuana growers should beware because "you will find no safe haven in 1984. We will spray and use U-2 surveillance aircraft and all the technological advances available in our cannabis eradication program."

PPH abusers swallow core or inject liquid

(from page 1)

epidemic "unless preventive measures are taken."

The irony of the situation is that PPH, originally accepted as being relatively harmless, is only 1/12th as strong as amphetamine, according to the manufacturers. Each inhaler contains a cotton core impregnated with 250 mg of PPH and aromatics, and sells for between $1 and $1.25 per unit.

Addicts make stove-top speed, or "peanut butter meth" as it is also called in the US, by refining cores and then injecting the resulting liquid. Other users swallow the cores.

One of the dead victims proved to have about 15 Benzedrex fillers in his stomach on autopsy, said Dr Anderson.

"I would say we're talking about acute toxicity in continual users," he continued, "and I'll bet you could easily more than double the number of attributable deaths that were probably not identified as resulting from propylhexedrine abuse.

"And Benzedrex is almost certainly being abused in places other than Dallas.

"We've also seen other inhalers like the Vicks, which contains an amphetamine-like product. Occasionally, pharmacists report kids coming into their stores and buying a whole bunch of Vicks. But Benzedrex is still the inhaler most abused in this area.

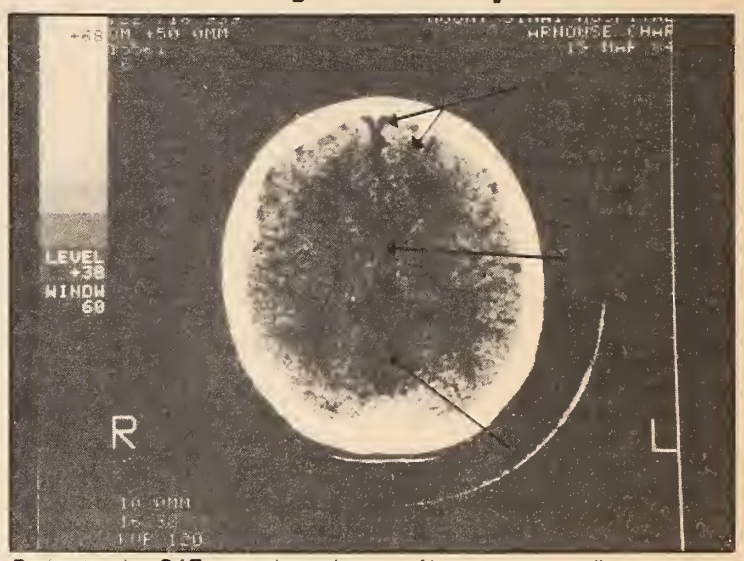
"The incidence of deaths in the US has dropped off largely, I think, because of the action taken by druggists. But we still see several deaths a year, and we identify new patients coming through the emergency rooms."

Dr Fornazzari said none of the patients seen at the ARF knew each other, yet each was injecting PPH into the jugular vein.

The first, an 18-year-old native girl, had been using MDA (methylenedioxyamphetamine) since she was 12 and, for six months prior to admission to the ARF late last year, had been injecting stove-top speed every two days.

She experienced transitory paralysis of her right eye, inability to swallow, atrophy of the right side of her tongue, and facial numbness. A CAT-scan also revealed cerebral atrophy. She had soft-palate anethesia and anemia.

The second patient, a 31-year-old white, male homosexual, had been using intravenous narcotics and MDA for 10 years, and stove-top speed daily for four years. He experienced generalized headaches and double vision for two hours after injecting PPH into his jugular.



Brain atrophy: CAT-scan shows legacy of 'stove-top speed'

He also had severe generalized skin ulcerations resulting from injections of PPH into arm and leg veins.

Patient three is 24 and white with an 11-year history of solvent abuse. He was "fixing" home-made Benzedrex preparations for two years prior to admission to the ARF. He experienced double vision and crossed eyes, as well as memory impairment. His CAT-scan indicates cerebral atrophy.

The fourth patient was also male, aged 32, with a long history of amphetamine and Benzedrex abuse. He died suddenly from pulmonary difficulties.

Post-mortem studies on the dead US victims showed severe cardiac and pulmonary abnormalities, said Dr Anderson.

Coca paste cheap for kids in Peru

(from page 1)

addict careers in their early teens. Today, many are only six or seven years old when they start to smoke.

Dr Jéri: "Boys and girls start to smoke cigarettes when they are six to seven then pass on to marijuana and then coca paste. We are now finding coca paste being given free, or sold as cheaply as sweets, to primary school boys and girls."

Many of the poor child addicts suffer from malnutrition. Tuberculosis is a secondary complication. As cocaine kills hunger pains, Dr Jéri adds, "I have seen patients who have been relapsing for 10 years. They still live because they are middle class and they can be fed and they can get hospital treatment.

"But there is a high mortality among the poor children. Many either commit suicide or are involved in fatal accidents."

Dr Noya says coca paste addiction is fatal in children unless it is interrupted. "They will die for sure. I don't think they will live more than two or three years if they continually smoke coca paste."

After my veins went, I used the jugular

TORONTO — Mary (not her real name) is 18 and has been abusing drugs, usually "speed," since she was 12. She was a prostitute, using much of her income to buy drugs. Her pimp introduced her to Benzedrex.

She describes the effects of injections of propylhexedrine, the active ingredient in Benzedrex, into her neck:

"First of all you get a heat rush through the body, and after that you get the high from it like you're speeding. It depends on the strength, but it lasts for maybe two hours . . . two to five hours.

"I started out with just the main lines in my arms, until they went, and I couldn't find them any more. After that I used veins on my arms and hands, and when I couldn't find those any more, I used veins in my legs.

"After they went, I used the jugular vein.

"In the middle of December (1983), after making up the speed, I got somebody to hit me up in the jugular and something happened to my tongue after that, and I couldn't move it. It's just going away now, the paralysis. Another time when I did Benzedrex in my neck, one of my eyes — the right eye — went paralyzed. It was the same side as I injected.

Abuser: my neck was numb

"My neck was already numb, so I didn't really notice anything about that. There was a little numbness in my face from one of the other injections and I've had numbness, minor numbness, in my hand and thumbs."

NEWS

US institutes move closer as users combine alc/drugs

By Anne MacLennan

DETROIT — Widespread use of alcohol with other drugs is drawing together the top two federal addictions institutes in the United States.

Historically, the institutes — one dealing with alcohol, the other with other drugs — have travelled different paths.

But the paths are now "starting to converge," Robert G. Niven, MD, director of the US National Institute on Alcohol Abuse and Alcoholism (NIAAA), told **The Journal** here.

He said talks between the NIAAA and the US National Institute on Drug Abuse (NIDA) are still informal and stem largely from concerns he and William Pollin, MD, director of the NIDA, share. However, they are considering formal collaboration on projects of mutual interest.

Although there were good reasons in the past to keep separate, "there are fewer good reasons today," Dr Niven said reflecting the shift from earlier thinking that alcohol and other drug use were totally different and separate phenomena.

Joint action would be aimed at enhancing research, education, and prevention activities of both agencies and would also involve other private and government bodies, including the US department of transport's National Highway Traffic Safety Administration, he said.

Although a priority would be trying to reduce morbidity and mortality resulting from vehicular accidents, there is a need to study the effects of alcohol and other drug use on people's performances on the job and in the home as well, he said.

"There are a lot of epidemiological studies, particularly in the area of vehicular accidents — hundreds of studies. There's less knowledge about drugs and trauma.

"But we've been working separately. Now we're looking to collaborate and enhance our efforts in this area. There are a lot of things we need to understand about the effects of alcohol and other drugs used individually and in combination."

Dr Niven later told meetings here of the American Medical Society on Alcoholism and the National Council on Alcoholism that collaboration could extend to conferences and grants review procedures, and would put to best use limited human and financial resources.

A recurring theme from Dr Niven during the four-day National Alcoholism Forum here was the importance of information exchange and the need for more and better communication both within and from the alcoholism field — to the public, other professionals, and the media, and to legislators, rule-makers, and policy makers.

Effective communication of science to the public is particularly important, he said, locally, regionally, and nationally.

He emphasized that with the "tremendous proliferation of data" and their potential for misuse and manipulation, the need is critical for people in the field to be precise and up-to-date.

"I don't think hyperbole does us a lot of good. We're a small field.

"If we're not able to get access to, appropriately understand, and appropriately communicate information, we're going to be at an incredible disadvantage," he added.

On research, Dr Niven said there is a need for "more and more, not fewer and fewer good investigators," but funding is not keeping pace with the number or quality of grant applications. Next year, he anticipates, only 24% of applications will be able to be funded.

"This gives the edge to established applicants and is a disadvantage to young and minority investigators. Our ability to do research training is gradually being eroded: it will result, in a few years, in progressively fewer researchers in this field," he warned.

Niven: mutual interest

The institute's budget for 1985 (fiscal) will increase by about $5 million — a 14% increase in the extramural research budget. Overall, funding will increase by 9% — "a greater percentage increase than in all the other institutes," but not enough, he said.

'Callous' treatment leads to trafficker's acquittal

VANCOUVER — A judge has acquitted an accused drug trafficker and censured police and a physician after finding they used "callous, painful, and totally unacceptable" methods to recover drugs from the man's body.

County Court judge Douglas Hogarth said Paul Truchanek, 26, concealed a balloon containing $11,000 worth of heroin in his rectum in March, 1983.

Officers, acting on a tip, grabbed Mr Truchanek in a parking lot, applied a choke hold to stop him swallowing drugs, and searched his mouth and clothing. Later, he was strip searched and taken to Shaughnessy Hospital, where Dr Anthony Koelink, on retainer to the RCMP (Royal Canadian Mounted Police), was on duty.

Mr Truchanek refused to be searched and was taken to Vancouver police headquarters, where he was held down while Dr Koelink tried to recover the drugs from the suspect's rectum, using various methods.

"I find that Truchanek was in considerable pain during this examination, and Dr Koelink was insensitive to it," said the judge, adding that the doctor displayed a "gross neglect" of ethical responsibilities.

The registrar of the College of Physicians and Surgeons of British Columbia, John Hutchison, MD, told **The Journal** that although he had not yet read the judgement or made a decision on whether to investigate the case, the behavior described by the judge was indeed unethical.

However, he said, "there are times when the laws of the land take precedence over ethics," offering as examples legal requirements that doctors report cases of certain infectious diseases and provide information on patients involved in motor vehicle accidents.

In the Truchanek case, Dr Hutchison acknowledged, the court has said there was no legal justification for the doctor's action.

PCP use rivals heroin in DC

WASHINGTON — Phencyclidine (PCP) use in the District of Columbia has risen alarmingly in the past year and now rivals heroin as the city's major drug problem.

District of Columbia police officials said PCP was implicated in 65 deaths, half of them homicides, during 1983; hospital admissions for overdoses rose to 376 in 1983 from 175 in 1982; and arrests for PCP possession went up to 1,047 from 310 in the same period.

Tax money could help, say MDs

Low funding limits Alberta agency

EDMONTON — The Alberta Medical Association (AMA) has implied that the provincial government here is underfunding the Alberta Alcoholism and Drug Abuse Commission (AADAC).

The AMA addressed the issues of alcohol and tobacco with the Canadian Medical Association task force on the allocation of health care resources, which is conducting hearings across the country.

The association said that the Alberta government reaps $279 million annually from beer and liquor sales, and "only a fraction of this amount" goes to the commission.

Noting that although the AADAC has developed excellent public education programs, the AMA said with a budget of only $23.6 million annually, the commission is limited in what it can do.

The association also wanted to ban tobacco advertising saying: "The elimination of tobacco advertising, and sanctions against the promotion of sports events by cigarette manufacturers, could do much to reduce disease and the cost of treating it.

"Greater taxes on tobacco could help underwrite the health costs which it (tobacco) generates."

As well, the AMA suggested a system of tax incentives for people who take pressure off the health care system by not abusing their bodies.

Smokers need not apply for police, firefighting jobs

FAIRFAX, VA — Fairfax has become the third northern Virginia county to prohibit the hiring of any police officer, firefighter, or deputy sheriff who is a smoker.

Future employees must sign a pledge that they are non-smokers and will remain non-smokers during their employment period.

But the rule adopted by the county board of supervisors does not apply to present employees who smoke or who may start the habit in the future.

The decision is mainly financial: under Virginia law, death or disability of a police officer, firefighter, or deputy sheriff from respiratory or heart disease, or high blood pressure, is presumed to have been caused by the job, unless it can be proven otherwise. Thus disability or death benefits must be paid out.

Coming up in

The Journal

- More from the US National Alcoholism Forum
- More from the PRIDE parents conference

Putting on the glitz at US conferences

By Wayne Howell

The last alcohol and drug conference I attended took place in Ottawa. Here are a few items from the agenda:

- Polydrug Abuse and Treatment Approaches;
- Perspectives on the Identification of Addiction;
- Neurological Complications Found in Alcoholism;
- The Role of Children in the Chemically Dependent Family;
- Substance Abuse and the Dilemmas of Marriage.

Twenty-five years ago, doctors in Saskatchewan warned Canadians what would happen if we adopted socialized medicine. But we didn't listen, and now we're paying for it with boring, insipid conference agendas like this.

South of the border, in the land of the free-enterpriser and the home of the brave entrepreneur, they did not succumb to the pinko-prophets of state medicine. No sir. They stood their ground against the socialist hordes and their horrid notions. They kept health care free of state intervention and made sure that medicine remained a private matter among doctor, patient, and the patient's banker.

And so it is that they can offer exciting, imaginative conference topics like these, from the agenda of the 6th annual meeting of The National Association of Alcoholism Treatment Programs to be held in Denver this month:

- How to Analyze Opportunities;
- Various Forms of Merger and Acquisitions — for the Acquiring and the Acquired;
- Bond Restrictions, Licensure, CONs, Stock Deals, and Assets/Liability Transfers;
- Merger and Acquisition Financing Mechanisms;
- Maximizing Reimbursement (prospectively or retrospectively).

What a contrast. These guys really know where it's at — they're out there on the cutting edge of the new technologies in alcohol treatment. None of this "role of the children" and "dilemmas of marriage" rubbish. They're talking stock deals and assets/liability transfers. None of this "neurological complications found in alcoholism" twaddle; they've got their fingers on the vital pulse of the industry — analyzing opportunities and maximizing reimbursement. None of this blather about "treatment approaches;" they're beyond those kinds of prosaic concerns — they're into the approaches the acquiring and the acquired should take to mergers and acquisitions.

There is no doubt about it — free-enterprise health care has kept the United States health care delivery system robust and innovative. In contrast, the Canadian system is sluggish and unimaginative, as the Ottawa conference topics indicate. Our system appears to be hung-up on outmoded concepts of patient care and client service; I did not hear one word about stock deals the whole time I was in attendance at the Ottawa conference. But I suppose there is no way to rectify this sad situation — we are mired so deeply in socialized medicine there is no getting out. I guess we'll just have to make the best of it.

NEWS

US teen cocaine use 'increasing dramatically'

By Harvey McConnell

ATLANTA — An explosion of cocaine addiction among teenagers and young adults in the United States is being picked up on the 800-COCAINE telephone hot line operated by Mark Gold, MD, and colleagues at Fair Oaks Hospital, Summit, New Jersey.

"We're seeing a real trend in the direction of high school and college age cocaine addiction, and cocaine is the only drug, to my knowledge, which is increasing in use dramatically by adolescents," Dr Gold told **The Journal**.

A preliminary study of callers by Dr Gold and colleague Linda Semlitz, MD, indicates young people develop addictive patterns within six to 12 months of starting to use the drug, compared with an average of four years in adults.

Dr Gold said the short age-to-insult pattern (the time between first use and addiction) is because young people are not fully formed physiologically or psychologically.

Dr Gold said measurements include physical, medical, social, school, and family problems. He said: "We get a lot of calls from university cities. As the end of the school year approaches, we hear from people who won't be able to finish the course, or will have to drop out of college, because of their cocaine addiction."

Most callers said they snort cocaine, "although we have a few intravenous users and apparently a lot of freebasers." About 80% of the young callers said they get money to buy cocaine from dealing or distributing the drug.

"We have had rare cases where kids found their parents' cocaine and then started to use and then sell the drug," he said.

Dr Semlitz, who with Dr Gold spoke at the international PRIDE parents conference here, said about 90% of young abusers are white and middle class "and it is important to remember that the average caller is not representative of the average user. Those who call the hotline define themselves as problem users, and most kids who use cocaine don't think they have a problem."

An initial appeal apparently is that cocaine "makes you feel good about yourself. But that lasts only about five minutes, and in heavy users it is not an issue. They are debilitated, depressed, and paranoid as adults."

Dr Semlitz said that almost without exception the young people are naively surprised at the questions they are asked by researchers; how did you know? and how did you guess what I am going through? are frequent responses.

The major difference between young people and adults is that instead of a two-to-one male slant, callers are almost 50-50 male and female.

"I think there is a good reason for that: many of the girls are involved sexually with active cocaine users, and that is how the girls get the drugs. Most girls don't deal," Dr Semlitz added.

Another group of young women calling the hotline don't identify themselves as having a drug problem but an eating disorder, or bulimia.

Dr Semlitz said, "They don't even use marijuana or alcohol particularly. What they have found is that cocaine curbs your appetite. Most bulimics think their eating-purging problem is out of their control. And what cocaine gives them, they think, is this full sense of control. The problem is that they are more out of control with cocaine than they ever were before."

Gold

Pollin

William Pollin, MD, director of the US National Institute on Drug Abuse, told **The Journal** that it is clear that overall the level of all drug use in the country has peaked and has started to come down.

"But within that still sizable group called users we still have some five million cocaine users, and some subgroups are starting to use it more heavily," he said. "Cocaine is much cheaper to buy and the supply has increased six-fold."

While some subgroups are using more heavily, findings are still compatible with indications that overall drug use is declining.

RESEARCH UPDATE

MDs fare better in alc/drug treatment

A comparison study of physicians and other middle-class patients treated for alcoholism and/or drug dependence confirms doctors have better-than-average recovery rates. Research at the department of psychiatry and psychology at the Mayo Clinic and Mayo Foundation, Rochester, Minnesota, examined 73 physicians in 1978, one to five years after treatment, and 185 patients in 1975, one year after treatment for drug and alcohol problems. Because of incomplete treatment, death, or inability to reach the patient, researchers were left with study groups of 53 and 141 patients respectively. Of these, 83% of the physicians had a favorable outcome, compared to 62% of the general group. This translated into favorable outcomes of 60% and 47% respectively for the entire original study populations. A favorable outcome was seen in more drug dependent physicians (95%) than those treated for alcoholism (84%) or those with a combined dependence (64%). The researchers noted that the structured monitoring system for the physicians with dependency problems is therapeutic in itself and said "perhaps the motivation to recover is stronger when the occupation at risk is high status, competitively sought, and identified closely with personal image and prestige."
Journal of the American Medical Association, Feb 10, 1984, v.251:743-746

Non-smokers more prone to ulcerative colitis

Smoking almost certainly has a preventive influence against ulcerative colitis, a form of inflammatory bowel disease, a British study confirms. Researchers from the university departments of therapeutics and community health, Queen's Medical Centre, Nottingham, England, carried out a case-control study examining current and past smoking habits of patients with ulcerative colitis, against age- and sex-matched controls. A total of 115 case-control sets were available for analysis. The study found the risk of developing ulcerative colitis was 3.8 times greater for non-smokers, rising to 6.2 times greater when smoking habits at the time of the onset of the disease were examined. The researchers said other studies have reported similar findings and, therefore, the chances of a coincidental association are "negligible." They concluded that "the association between non-smoking and ulcerative colitis is real, that it reflects habits before the development of illness, and that non-smokers may directly or indirectly have an increased liability to the disease."
British Medical Journal, March 10, 1984, v.288:751-753

Alcohol consumption/cancer link studied

A 14-year study of 8,006 Japanese men in Hawaii has shown a strong relationship between alcohol consumption and rectal cancer, and a significant link between alcohol consumption and lung cancer. Information on alcohol consumption was obtained through interviews in the mid-1960s. The men were then followed until the end of 1980 for signs of the five most frequent cancers (stomach, colon, rectum, lung, and prostate) seen in their population group. Results, adjusted for the effects of age and cigarette smoking, showed significant, positive associations between drinking and rectal and lung cancer only. The relative risk of rectal cancer was found to be greatest in men who reported consumption of 15 litres of beer or more per month. The risk for lung cancer was greatest in men who drank large amounts of wine and whiskey. However, the researchers, from the biometry branch of the cancer cause and prevention division of the National Cancer Institute, and the Kuakini Medical Center, Honolulu, cautioned that the relationship with lung cancer was not nearly as strong or as consistent as the relationship between alcohol consumption and rectal cancer. They could suggest no specific mechanism for these relationships and noted that the low level of alcohol consumption seen in the study group makes the findings of questionable value.
New England Journal of Medicine, March 8, 1984, v.310:617-621

Coffee and pancreatic cancer link

An analysis of international data strengthens the hypothesis that there is a strong link between coffee consumption and pancreatic cancer. Researchers from the department of community health and preventive medicine, Northwestern University Medical School, Chicago, measured per capita coffee imports and consumption and a number of other variables for 1957 to 1965, against age-adjusted pancreatic cancer death rates in 22 countries, including Canada and other developed nations, in 1971 to 1974. A highly significant relationship between the coffee measures and pancreatic deaths was "generally sustained" when the analysis was controlled for total dietary fat, cholesterol, tobacco, cigarettes, and national income.
American Journal of Epidemiology, Nov 1983, v. 118: 630-640

Pat Rich

Officials fear 'copycat' cases

Inhalant inquest goes public

By Tim Padmore

NEW WESTMINSTER, BC — Three coroners and two secretaries, the entire staff of the New Westminster district coroner's office, debated their dilemma.

Yet another child had died from deliberately inhaling Pam cooking spray. The dilemma was whether to call a public inquest.

To do so would, in effect, advertise the abuse potential of the product. Past experience had taught that more abuse, and more deaths, could result.

But there was another factor this time: a dangerous myth was circulating.

Both a CBC (Canadian Broadcasting Corporation) reporter and the RCMP (Royal Canadian Mounted Police) officer who investigated the death had told the coroner's office that children they had interviewed consistently told them: "We know it's dangerous. But as long as you don't do it very much, then the oil won't coat your lungs and you'll be OK."

In fact, Pam's freon propellant is the dangerous component of the cooking spray and can precipitate irregularity in the heart beat on the first exposure. The oily lecithin, which is the active ingredient, is relatively harmless.

Investigating coroner Chuck Standish told The Journal: "We really weighed it back and forth."

Finally, the consensus was to go public with an inquest.

Mr Standish, who said his own 11-year-old daughter told him she was aware of older children abusing the spray, said he hopes the inquest will produce recommendations that will lead to a province-wide education program in the schools, probably carried out by the ministry of health through public health nurses who regularly visit the schools.

Pam: a dangerous myth

He added: "Maybe if we make it public then the store owners will know and make it a little harder for the kids to buy it."

The inquest will examine the death of Jason Koe, 14, of Surrey, British Columbia, who died February 21.

RCMP constable Debbie Curtis said Jason's mother came home to find him locked in the bathroom, slumped against the door; it later emerged he had been sniffing the spray with a friend.

Gillian Willis, spokesman for the provincial Drug and Poison Information Centre, said freon abuse is frighteningly dangerous.

One reason is that the effects seem to be erratic. An abuser may survive many sessions without ill effects, and then suffer a fatal attack, she said.

A second is that it is fast-acting, and has a short duration of action (a half-life in the body of only 15 minutes).

"In a typical situation you have a bunch of kids who start sniffing and one gets in difficulty, the friends panic and leave, and then they go back, but by then it's too late and the kid is dead."

There have been three cooking spray deaths in BC since Pamela McKellar, 13 years, also of Surrey, died in July, 1982.

One was a clear copycat case: a 51-year-old woman committed suicide and made it plain she was inspired by a newspaper clipping of the McKellar inquest.

That inquest recommended a ban on aerosol sprays of any kind, something that Mr Standish is not pushing for.

Freon propellants have been banned in the United States, but the principal reason was concern that freon was destroying the upper atmosphere's ozone layer, which protects the earth from ultra-violet radiation.

In the US, freon, a fluorine-based compound, has been largely replaced with similar substances based on chlorine. These have low abuse potential but have the counterbalancing risk of high flammability.

"Gosh, Helen, I've never seen George enjoy himself so much at a party! When did he quit drinking?"

Heroin and pain relief

While Canada's attempts to test heroin's effectiveness as an analgesic for pain in terminal cancer get bogged down in technical difficulties, the movement to legalize the drug as a therapeutic agent is gaining ground in the United States.

A bill expected to go before Congress shortly would, if passed, "establish a temporary (five year) program under which diacetylmorphine will be made available through qualified (hospitals) for the relief of pain from cancer."

In the last several months, the bill has moved quickly. In March, The Compassionate Pain Relief Act was approved by the US House of Representatives Subcommittee on Health and the Environment, chaired by Congressman Henry Waxman. In April, the bill, also known as House Resolution 4762, was approved by the full committee (Science and Technology).

*In Canada, however, plans to start the "heroin trials" in the fall of 1983 (***The Journal,** *July 1983) have been held up, and officials are unable to say when they may begin. Once the heroin trials do begin, it will be at least two years before the investigating committee will report the outcome — and some time after that before a decision is made on whether heroin has a place as an option for pain management in Canada.*

Arnold Trebach* *presented expert testimony to the US subcommittee.* **The Journal** *presents Dr Trebach's testimony in its entirety.*

For 12 years, the major focus of my research and teaching has been the comparative history of drug abuse control and treatment. The drug which has drawn most of my attention has been heroin, one scientific name for which is diacetylmorphine.

When I first entered this field in the early 1970s, I assumed that doctors and policemen were the only professionals qualified to work in it — and that, between them, they had matters pretty well under control. Within a short time, however, I discovered that nothing could be further from the truth. Matters were not at all under control. Doctors and policemen, as well as pharmacologists and lawyers and criminologists, I found, worked in this field in reliance upon historical distortions and, sometimes, outright scientific falsehoods. Members of these professions have often been frank with me in confessing, either in print or in private, that their education provided only a rudimentary knowledge about the dynamics of psychoactive drugs and that most of their schooling had been on their own in the school of hard knocks.

Dr Andrew Weil wrote in 1972 that he had received no education on drug abuse during his entire Harvard Medical School education, with the exception of one extracurricular lecture.[1] A pharmacist-pharmacologist told me that he attended two of my London institutes because, while his education on most drugs and medicines had been superb, he was taught a confusing melange of misinformation on the effects of psychoactive drugs on humans.[2] Leading lawyers and criminologists, to my keen embarrassment, often cite false facts from tertiary sources, handing down myths from one generation to the next.

Early on, then, I determined that one of my major goals in this field would be to get the facts straight, whether they supported the positions closest to my heart and emotions, or not. One of my major methods, I decided further, would be to handle claimed facts the way a lawyer would prepare for a trial — if there was evidence to support them, then the facts might be true, but only so far as the evidence went. Sticking closely to the available evidence, one plus one always equals two. My study of the history of drug abuse control has found, time and time again, that one fact added to another, plus a dash of hope, a pinch of myth, and a good dose of fear has been totalled to equal five. Such false sums, repeated so often during this century, have helped to create the disaster in drug abuse control we now face.

Professional myths

A good case in point of such a false sum is found in the story of the banning of heroin from medicine in the US. The prevailing professional myths in this country declare authoritatively that heroin was discovered in 1898 by the German pharmacologist Dreser, and that it was marketed by his firm, Bayer, as a non-addicting cure for morphine addiction. In fact, the drug was discovered in 1874 by English chemist C. R. Alder Wright. Later, Dreser experimented with it, then gave it its popular name, and highly praised it in a speech in 1898. I have found no evidence that Dreser, or the Bayer firm, ever promoted it as a cure for morphinism, although Dreser did say it was apparently non-addicting. Dreser strongly recommended it as a treatment, not a cure, for the pain, anxiety, and discomfort of two of the most deadly diseases of the time, pneumonia and tuberculosis.[3] Even in recent years, some English cough syrups, including those for children, contained a tiny amount of the drug.[4]

Such medicinal use of heroin in the treatment of organic sickness soon spread to many countries, including the US. By the beginning of the second decade of this century, for reasons no one can explain, it began to be a very popular drug for non-medical and recreational use. When the US Congress passed the Harrison Narcotic Act in 1914, it banned such recreational use but it did not, of course, ban the use of heroin in medicine. In fact, the law was a sound piece of legislation which restricted the use of opiates and cocaine to medical practice. In the words of the act, a registered physician could prescribe these controlled drugs when acting "in good faith" or "in the legitimate practice of his profession." I have read the scant surviving record of the deliberations on this act and, while many issues about the legislative intent of the framers are unclear, there is sound evidence that they firmly intended that all of these opiates, including heroin, were to remain available to doctors and patients suffering from such diseases as cancer.

Soon after the passage of the Harrison Act, two important trends became observable. Recreational use of heroin grew, along with an emotional campaign to rid the country of the substance itself — to make the country heroin-free.

Thus, on April 3, 1924, 60 years ago, the House Ways and Means Committee met to consider an amendment to the law restricting the importation of opium to medicinal purposes, by then titled the Narcotic Drugs Import and Export Act of 1922. The amendment held this one phrase: "**Provided**, that no crude opium may be imported for the purpose of manufacturing heroin."

Five witnesses appeared in support of this proposal; none opposed it. No original or empirical evidence was introduced to demonstrate that there was a connection between the creation of addicts and the presence of this drug in medical practice. No such evidence was produced to demonstrate a significant amount of diversion of the drug from legitimate medicine to the black market. Expert professional witnesses testified to facts which were distortions or unsupported by known evidence.

District of Columbia physician Charles Richardson presented the position of the American Medical Association in favor of banning heroin. When asked if other drugs could replace heroin in medicine, he replied "absolutely" and suggested that codeine would be a good substitute. Surgeon General Rupert Blue was asked if the drug produced insanity and he replied, "oh, yes." The Surgeon General also testified that, "the drug being more poisonous," it could shorten the life of a user more quickly than morphine. Criminologists testified to the committee that the drug produced "an unmoral savage" capable of committing any crime, in part due to quicker muscular reflexes created by the drug, and that no other drug produces such a disregard for the conventions and morals of civilization.

None true

None of these fear-producing claims is true. To state that addicts denied the drug have been known to perform outrageous acts is one thing; to declare that the drug itself produces such aberrant behavior or is organically harmful is unsupported by any sound evidence, then and now.[5]

Also introduced at the 1924 hearing were reports from the New York City health and police departments, which contained some interesting information that might have been interpreted in opposition to the premises underlying the proposed amendment. One report on a study of 10,000 drug addicts observed that "only 2% of those arrested can trace their addiction to medical treatment." Another report estimated that in 1924 at least 76,000 ounces of heroin were sold on the black market in New York City alone, while in the entire state all 14,715 physicians legitimately prescribed only 58 ounces. No member of the Ways and Means Committee nor any witness suggested that these facts strongly demonstrated the lack of an evidentiary link between:
(1) the presence of the drug in legitimate medicine and,
(2) the sale of the drug on the black market.

Diversion of the drug from legitimate channels and the creation of addicts by doctors were assumed, but without sound evidence. One and one equalled five. The committee voted to support the legislation unanimously. On June 7, 1924, the amendment became law after both Houses of Congress passed it unanimously.

Many authorities, including agencies of the US government, periodically report that this action banned heroin in medicine totally.[6] This was the clear intent of the support-

Trebach: fear-producing claims unsupported by evidence

ers of the law, but, in fact, doctors and legitimate drug businessmen who legally owned heroin on that day could continue to use it in medicine. However, only a minority did, and licit use of the drug diminished greatly.

The Narcotic Control Act of 1956 finally declared all heroin to be contraband. Starting on November 18, 1956, heroin was totally banned in US medicine. Consistent with that action, the Comprehensive Drug Abuse Prevention and Control Act of 1970 placed heroin in Schedule I, indicating that it has "no currently accepted use in treatment."

It is my position that there was no rational evidentiary support for the restrictive Congressional actions regarding heroin in 1924, 1956, or 1970. All were based on false sums, inflated largely by misinformation and fear. Can Congressional action in 1984 begin to correct the errors of the past? We can start by taking a fresh look at the available evidence bearing on all sides of the issue today.

Therapeutic potential

As I was in the process of reviewing the background of this bill, I was forcefully struck by the fact that several of the key arguments in support of the ban in 1924 are being asserted with full force today. No expert now seriously argues that heroin produced insanity or organic damage. However, opponents of change today rest their position on two venerable points: first, that there is no unique advantage to this drug in the treatment of the organically ill; and, second, that its presence in the pharmacopoeia presents immense dangers of diversion and the addiction of our people because heroin is so attractive to non-medical users.

When Gene R. Haislip, director, office of compliance and regulatory affairs, Drug Enforcement Administration (DEA), testified on September 4, 1980, regarding a roughly similar bill, he stated he had reviewed the legislative history of the 1924 amendment and saw in it a clear Congressional intent to ban heroin for these two reasons. He observed in a persuasive statement that the administration of then-president Jimmy Carter, the DEA, and he, personally, would take a different view "if the factual determination is made by scientists based on the facts, that heroin possesses a unique benefit that is not satisfied by other drugs to relieve some segment of suffering people." This also was the position taken at that time by Stuart L. Nightingale, MD, acting associate commissioner for health affairs, US Food and Drug Administration (FDA).[7] It is my distinct impression that these were sincere concerns of these dedicated professionals and deserve the most serious response concerning the therapeutic potential of the drug in treating organically based pain.

For years, I thought the keystone in a solid arch of argument on the unique benefits of heroin in cancer care was the research work of Robert Twycross of England, a distinguished pharmacologist and hospice director. (I have visited his hospice in Oxford, and he has lectured on several occasions in my London institutes.) However, in 1980, Dr Twycross wrote me that he had a change of heart, which I duly

Table 1

Actual Consumption of Heroin and Morphine in England (1971-1982) (in kilograms)

	1971		1972		1973		1974		1975		1976		1977		1978		1979		1980		1981		1982	
	Amt.	%	Amt.	%	Amt.	%	Amt.	%	Amt.	%	Amt.	%	Amt.	%	Amt.	%	Amt.	%	Amt.	%	Amt.	%	Amt.	%
Heroin	41	10%	43	12%	48	12%	57	15%	57	15%	62	18%	73	20%	88	23%	96	27%	107	22%	134	26%	154	31%
Morphine	364	90%	318	88%	363	88%	322	85%	313	85%	286	82%	295	80%	289	77%	266	73%	387	78%	373	74%	348	69%
Total	405	100%	361	100%	411	100%	379	100%	370	100%	348	100%	368	100%	377	100%	362	100%	494	100%	507	100%	502	100%

Sources: Arnold S. Trebach, *The Heroin Solution* (New Haven: Yale University Press, 1982), p 305; United Nations International Narcotics Control Board, *Statistics on Narcotic Drugs for 1982* (New York: United Nations, 1983), pp xv and 60-61.

**Dr Trebach is a PhD professor, and director of the Institute on Drugs, Crime and Justice, School of Justice, The American University, Washington DC. One of the main functions of the institute, which Dr Trebach established in 1974, is the presentation of intensive international seminars on comparative drug policy in London. Dr Trebach is also the author of* The Heroin Solution.

noted in my book. I was forced to write of two overlapping portraits of this distinguished pharmacologist. One indicated strong support of heroin as "an indispensable, potent, narcotic analgesic" in the treatment of far-advanced cancer. The second warned me that he could not lend support to the US campaign to provide heroin for cancer treatment because "the doctors who use their present narcotics badly . . . will use heroin just as badly, and, in practice, patients will be no better off."[8] This was disappointing and confusing to me but I accepted it as part of the often conflicted nature of this field. Those advocates of medicalized heroin who do not face up to the significance of Dr Twycross' change of position are ignoring an important piece of the total evidence in this matter.

Indeed, when I reflect on the large number of original scientific studies about heroin I have read in recent years, one fact is pervasive: all of them are, in a sense, conflicted. Not a single one of these studies states in layman's terms that one strong narcotic is a winner, far ahead of the pack, on all major features for the treatment of any type of organically-based pain such as cancer. Not morphine; not methadone; not Dilaudid; not heroin; and not any of the other numerous drugs. In some patients, one drug relieves pain rapidly but causes nausea. Another has only a few bad side effects but does not act rapidly enough. It is as if the score at a football game was not simply, say, 38 to 9 in favor of the victor, but rather a composite listing by quarter in terms of success in passing, yards running, time of possession, and so on: 56%, 88 yards, nine minutes.

Equivocal evidence

It is unlikely that any amount of research will ever produce the clear statement that any drug, including heroin, is *universally* superior. I am afraid we must work with the equivocal evidence we now have. In my opinion, that is quite good enough, for it demonstrates that when some patients are prescribed heroin, they are greatly helped by it. The medical literature contains many reports of cautious experiments which indicate that heroin acted better than other opiates, such as morphine, in terms of quicker analgesic impact, greater calming power, and, in the words of an article in the *British Journal of Anaesthesia*, "fewer emetic sequelae;" that is, fewer of the patients in the experimental sample vomited after being given heroin as preoperative medication. While medical scientists may *report* on such experiments, none can *predict* which patient will be helped because science finds it difficult to take into account the emotional and personal factors that affect the way drugs work on human beings. The attitudes of patients and doctors may increase or decrease the pain-killing effect of a particular medicine. Most aspects of psychoactive drugs are subjective and idiosyncratic, not at all suitable subjects for mathematical modelling or predictions. The only way any doctor can tell if a patient may be helped by heroin is to provide it to that person and observe the results.

In the end, only by that type of clinical test and observation on real cancer pain may the questions about heroin be properly answered. That is why I so strongly support this bill. It provides for a courageous and realistic temporary program over a period of five years on this one type of illness which should produce the type of information that Mr Haislip and Dr Nightingale and other concerned officials have been asking for. Such officials and their agencies should support making heroin available for cancer patients under this bill so that this noble venture may move forward. In no other way will reliable evidence be produced on which the country may make judgements about the use of this drug in the treatment of the organically ill. Further traditional and more limited medical experiments simply will not cut the mustard.

Of course, it is important that we remember that one related but somewhat broader experiment has been going on elsewhere during most of this century — in the United Kingdom. English physicians have always had the clinical freedom to choose any of the narcotics, including heroin, to treat patients suffering from organic illness. While it has sometimes been reported by heroin proponents that 39 countries widely use heroin in medicine, the available evidence suggests that only in the UK has there been steady use for many years of a significant quantity of licit heroin. More than 95% of all licit heroin legally consumed during recent years in the world has been prescribed by English doctors (in 1982, as it happened, 98.7%).[9] If heroin indeed has no unique advantages, it would seem that English physicians would have dropped their usage drastically. They have a choice. It occurred to me, as I was finishing my book several years ago, that the freely made choices of these doctors and, by implication, their patients, might be the most important objective scientific information that could possibly be produced up to that point in history. I kept reading reports from officials in the US that the English were dropping the licit use of heroin. When I put the data together, I found the exact opposite. In 1971, total consumption of heroin in the UK was 41 kilograms; of morphine, 364 kg. By 1979, English physicians had freely chosen to more than double heroin prescriptions (primarily, I have been told by Home Office experts, in cancer cases) to 96 kg, while dropping morphine to 266 kg.

Thus, out of the total of 362 kg of both drugs used in 1979, 27% was heroin and 73%, morphine. By 1982, use of legal heroin had risen to 154 kg (almost fourfold the 1971 figure) while morphine consumption was 348 kg, for a total of 502 kg. The ratio of heroin to morphine in that year was 31 to 69. It would not seem unreasonable, then, to use as a rough working guide the rule that for every seven kg of morphine, the English now use three kg of heroin.[10] **Unlike all the medical experiments, these tabulations are not equivocal. They show a definite place for heroin in medicine, not superior, to be sure, but secure and vital.**

Table 2

Possible Consumption of Licit Heroin in the United States Based Upon the British Experience (1978-1982) (in kilograms)

	1978		1979		1980		1981		1982	
	Amt.	%	Amt.	%	Amt.	%	Amt.	%	Amt.	%
Possible Amount of Heroin*	225	30%	137	30%	206	30%	212	30%	228	30%
Actual Amount Morphine**	526	70%	319	70%	480	70%	495	70%	533	70%
TOTAL	751	100%	456	100%	686	100%	707	100%	761	100%

*Assuming a consistent ratio of three to seven for heroin and morphine.
**Source: United Nations International Control Board, *Statistics on Narcotic Drugs for 1982* (New York: United Nations, 1983), 60-61.

If doctors and patients in the US were given similar choices, it is likely that a similar secure place for heroin would be found in medicine in this country. Of course, it is probable that at first heroin would be used with greater caution and in a fewer number of cases than in the UK. Even if the use of heroin in medicine became widespread in the US, it is doubtful if it would exceed the English ratio of seven-to-three. Applying that ratio to the 533 kg of morphine legally consumed in the US in 1982, we arrive at 228 kg of legal heroin as the highest imaginable amount that might ever be needed in this country to carry out the experiment provided by this bill during the next five years.[11] Like all projections in this field, this is simply an educated guess, but it seems in line with the order of magnitude implied by the available evidence.

Let us now return to the second major objection to this bill as posed by the administration in 1980. As Mr Haislip observed, "because of its unique relationship to the illicit traffic . . . it is clear that the drug would pose a major problem of diversion." In other words, once the drug was allowed to slip back into legitimate medicine, the pressure on all those in the legal trade would be immense to sell off some supplies in the black market. Also, the drug would be tempting targets for robbers. These are the most powerful political and practical arguments against the medicalization of this drug. Those who deny the reality of this problem, and many heroin advocates do, are ignoring the evidence of experience.

Human nature being what it is, a portion of these drugs *will* be diverted to the black market. But what portion? English experience suggests that it will be minuscule. With all of the legal heroin in the UK, the evidence demonstrates that most of the heroin on the black market is imported illicitly from the Middle and Far East.[12] There have been a limited number of robberies and burglaries of pharmacies, but the total amount of drugs stolen has not been great.

In this country, I suspect, the threat of violent robberies will be greater and more precautions must be taken. It might be wise to place heroin in the first years only in those pharmacies which have a high level of security, perhaps in hospitals. Fortunately, the protection of valuables in a fixed location is a function well within the art of law enforcement. Even the best police force cannot prevent people from using illegal drugs, but good law enforcement planning can significantly reduce robberies and thefts of any substance. Today, hospitals are constantly in the security business to protect legal narcotics and supplies of cocaine, valuable and dangerous radioactive materials, and x-ray plates containing silver.

Worst scenario

Let us for the moment, though, grant the most horrible dreams of opponents of medicalization and construct a worst-case scenario in the US. Suppose that the federal government did authorize the manufacture of the seemingly high amount of 228 kg annually. Next, what if through a massive robbery, or a stroke of bad fortune, this entire annual production, 502 lbs of pure heroin, were diverted to the black market? Would this cause a disaster for US society? Not necessarily. Indeed, when that amount is compared to the total amount now consumed illegally in the US — that is, when we look at the available evidence calmly and do not inflate it with fear — it is highly likely that 228 kg of heroin dumped onto the huge US black market would be barely noticed by anyone.

Estimates of the heroin black market have varied over recent years. In 1978, President Carter's Office of Drug Abuse Policy (ODAP) used two different formulas for estimates of the market as of 1976. Calculating the amount that addicts and chippers (less-than-daily users) might consume, the ODAP arrived at an annual figure of 10 metric tons. Looking at the amount of the world market available in the US, the ODAP estimated 6.16 metric tons. The office then suggested an average figure of eight tons.[13] The latest estimate I have seen is of 4.08 metric tons imported into the US in 1982, which was made by the US National Narcotics Intelligence Consumers Committee.[14] In my opinion, that estimate is very low, but I will use it for purposes of projections in this worst-case scenario along with the high estimate of 228 kg as the amount of legal heroin produced and then diverted. The result is that all of the new, legal heroin would supply only 5.6% of the 1982 level of illegal demand. A more modest worst case would show that amount of legal heroin meeting only 2.9% of the illegal market as reflected in the more realistic Carter-ODAP estimate of eight metric tons.

If either scenario occurred, there would be mixed results. In some communities, it is possible that a few more addicts and chippers might have more heroin available to them on the black market. At the same time, the slightly greater supply might well reduce the price on the black market and when heroin prices go down, crime tends to go down also. Thus, there might well be a few less robbery and burglary victims.

We must then place in this equation the fact that one of four living US citizens — 50 to 60 million people — may well succumb to cancer — perhaps two million in the next five years.

Approximately half of them may require some form of analgesic. No one can predict, as we have seen, which medicine will help them until it is administered. In light of all this, the dangers of diversion of legal heroin somehow seem well worth the risk, such as it is.

Risk-balancing

We must place another value conflict into this risk-balancing process — whether we hate the thought of addicts using illegal heroin so much that we are willing to accept the risk of allowing some cancer patients unnecessary agony. I have already said that the dimensions of the possible supply of diverted drugs would be quite small. Nevertheless, for the purposes of this argument, what if we knew with certainty that the presence of legal heroin in America for cancer patients would provide both a significant supply of drugs for street addicts and also the high possibility of pain relief for many cancer patients? Using our present set of operational values, we seem to be saying: the cancer patients must suffer so that we can keep this drug away from dope fiends. In practical terms, this position represents a cruel irony because our massive interdiction and enforcement programs are failing, utterly, to keep heroin out of the veins of street addicts. In ethical terms, this position is a perversion of every moral principle that rests close to the gentler hearts of our people. It is time the moral perversion stopped.

We must recognize, finally, that the message that Congress should be sending out by passing this bill goes far beyond the idea of giving a particular drug to cancer patients. Congress would be acknowledging that the enforcement of our drug laws throughout most of this century has terrorized the healing professions regarding the use of all powerful drugs in pain control. As a result, many US doctors, nurses, and, indeed, patients seem to accept the inevitability of much pain within medical practice. While some types of pain *are* unavoidable, the word would go out from Capitol Hill that chronic and prolonged cancer pain is no longer considered inevitable —and that every innovative idea is now acceptable to deal with it aggressively and humanely. The arrival of heroin in medicine, then, may well unlock the imagination of the medical profession and result in the better use of existing drugs as well as new treatment not involving narcotic drugs at all.

1. Andrew Weil, *The Natural Mind* (Boston: Houghton Mifflin Company, 1972), p 12.
2. The identity of the participant in the London drug institute is John Cox, RPh, CCDP, vice president and director, Metropolitan Clinic of Counseling, Minneapolis, Minnesota.
3. The early history of heroin is related in Arnold S. Trebach, *The Heroin Solution* (New Haven: Yale University Press, 1982), Chapter 3.
4. Horace Freeland Judson, *Heroin Addiction in Britain* (New York: Harcourt Brace Jovanovich, 1974), pp 3-4.
5. Hearings Before the Committee on Ways and Means, House of Representatives, on H.R. 7079, *A Bill Prohibiting the Importation of Crude Opium for the Purpose of Manufacturing Heroin*, April 3, 1924 (GPO 1924). The 1924 hearings are discussed in *The Heroin Solution*, pp 49-52.
6. See, for example, a report issued by the National Clearinghouse for Drug Abuse Information of the Department of Health, Education, and Welfare, *Heroin*, Series 33, No 1, p 14. Also see Edward M. Brecher, *Licit and Illicit Drugs* (Boston: Little Brown and Company), p 51.
7. Hearing Before the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce, House of Representatives, On H.R. 7334, *A Bill to Amend The Controlled Substances Act to Authorize the Use of Heroin for Terminally Ill Cancer Patients*, September 4, 1980 (GPO 1980), pp 124-67.
8. The work of Dr Twycross is described in *The Heroin Solution*, pp 68-74.
9. United Nations International Narcotics Control Board, *Statistics on Narcotic Drugs for 1982*, (New York: United Nations, 1983), p xv.
10. Only a small amount of heroin is now used in England for the treatment of addicts. In 1978, for example, out of the total 88 kg of heroin licitly prescribed in the UK, 8.5 kg were provided to addicts. *The Heroin Solution*, p 78. I suspect current ratios would be in this ballpark and thus there seems no need to change the estimates in the text (3-7 for heroin and morphine) which relate only to treating the organically ill.
11. See Table 2.
12. Letters, Richard Hartnoll, Roger Lewis, Peter Dally, MD, and James H. Willis, MD, *British Medical Journal*, August 13, 1983, p 500. Letters, Ann Dally, MD, and Dale Beckett, MD, *British Medical Journal*, October 22, 1983, p 1219.
13. White House Office of Drug Abuse Policy, *1978 Annual Report* (GPO 1978), pp 59-63.
14. Drug Enforcement Administration, The National Narcotics Intelligence Consumers Committee, Narcotics Intelligence Estimate — *The Supply of Drugs to the US Illicit Market from Foreign and Domestic Sources in 1982 (With Projections Through 1983)* (DEA, 1984), p 2.

FEATURE

Addicts have little hope of recovery

Coca paste abuse — a 'burgeoning disaster'

In January 1978, **The Journal** *ran a series of reports from Bolivia, Peru, and Colombia by contributing editor* ***Harvey McConnell.*** *One described serious adverse effects of cocaine among abusers and addicts seen by Nils Noya, then director of the Bolivian National Institute for Investigation of Drug Dependence.*

As Dr Noya acknowledges, **The Journal** *articles "put me in the news," leading to stories in other publications, "even an international men's magazine."*

But the scientific parochialism endemic to North America led most of the substance abuse field to ignore his findings and warnings.

Dr Noya attributes this mistrust and scepticism to the fact that cocaine was then only available to the rich; to a rigid belief that cocaine produces only "psychological addiction," which "shows their ignorance of what addiction means;" and, above all, "because studies carried out in underdeveloped countries are not considered serious and trustworthy because they do not come with the support of what is called 'scientific research.'" (As Dr Carlton Turner, director of the United States White House Office on Drug Abuse Policy, has put it: the operation of the "NIH — Not Invented Here — Syndrome.")

Lawlessness in south Florida, presidential anti-drug task forces, the 200,000 calls made in the past year to the 800 COCAINE hotline in the US (See — US teen — page 4), and major conferences on treating cocaine addiction bear witness, six years later, that Dr Noya was right and the doubters manifestly wrong.

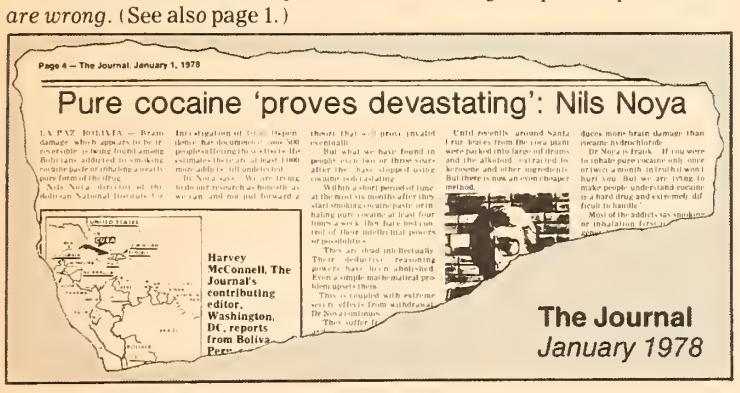
This spring, Dr Noya and Mr McConnell met and talked at length again, this time at the international conference of the PRIDE parents organization in Atlanta, where Dr Noya was a featured speaker.

Three years ago, Dr Noya left his post in La Paz and moved to Santa Cruz, the jungle heart of the cocaine-producing area in Bolivia. His minuscule government pay as director of rehabilitation and prevention services there is supplemented by his private medical practice, but his focus remains cocaine addiction.

Today, he sees an additional threat — large-scale shipment of coca paste (the first product of the extraction from the coca bush leaf) to North America and Western Europe. This time Dr Noya hopes his predictions are wrong. (See also page 1.)

McConnell Golobitsh

Bolivia, Colombia, Peru: scapegoats for the world's drug problems? Above, a Colombian child. In Bolivia (right) coca leaves by the sackful



Page 4 — The Journal, January 1, 1978

Pure cocaine 'proves devastating': Nils Noya

Harvey McConnell, The Journal's contributing editor, Washington, DC, reports from Bolivia, Peru.

The Journal
January 1978

. . . the effects are inhuman

Some are only eight or nine years old. But, whatever their age, coca paste addicts share one similarity: "It is just as if they have been let out of a concentration camp in 1945: you see cadavers walking. It is inhuman."

Dr Noya sees them every day in Santa Cruz. They are among the hundreds of thousands of coca paste addicts in Bolivia, Peru, and now, Colombia — visible evidence of what can happen as the coca paste octopus spreads its tentacles across the rest of South America, and probes north, into the US and Canada.

And Dr Noya, as well, sees the vultures most days. "Children go into the jungle to smoke, and some never come out. You know they are dying because you can see the vultures flying in and out."

By Harvey McConnell

Perhaps hardest to deal with, day in and day out, is the knowledge that no matter how hard anyone tries, there is no hope: coca paste is so powerfully reinforcing, it seems impossible for all but the exceptional to give up.

Dr Noya: "The only thing we can do is prevention: to tell them the truth about what coca paste could do. As for rehabilitation and treatment? We are dead. We don't have the resources. We just don't have the money. And even if we did, it wouldn't make any difference.

"We have sent patients with parents who could afford it to Argentina and the US for six months' treatment. And when they return, within hours, I mean two or three hours, they start smoking coca paste again. All they need to do is smell it.

"I want to let people in North America know how dangerous coca paste is and what a disaster it will be if it starts to become available here.

"There is absolutely no question it is more dangerous than cocaine hydrochloride (the white powder). The effects of coca paste smoking are similar to those of injecting cocaine hydrochloride or smoking cocaine hydrochloride (freebasing), but even more intense.

"I have known people who have used cocaine hydrochloride for 40 years on a social, once-a-week basis, like a glass of whiskey at the end of the week. With coca paste, such control does not exist. As soon as you become addicted, there is no possibility of your giving it up — ever — unless you have a really special personality.

"We have proven that all the people who smoke cocaine sulphate (coca paste) become more addicted in a short time: two weeks, generally, sometimes only four or five days.

"Even with one coca paste cigarette, people become paranoid. As they start smoking more, they begin to hide, they don't want to be with other people. In the English terminology of addicts, they lose every chance of social relationships, and they do not realize what they are doing to themselves or to their families.

"They are psychotic. They live in their own world. They lose touch with reality. You see them every day. Most addicts don't want to quit, although they think they can quit whenever they like. But, of course, they can't.

"Some people who used to use cocaine hydrochloride now prefer coca paste. They tell us it is much better: they feel a much stronger 'high' and, besides, coca paste costs less and is easier to get."

Dr Noya points out that coca paste contains not only the cocaine alkaloid, but also impurities such as kerosene, sulfuric acid, and tar — byproducts of the extraction of paste from coca leaves.

He and his colleagues have observed that intranasal use (snorting) of cocaine hydrochloride is self-limiting because of the drug's anesthetic and vasopressor effects. Coca paste leads to intoxication, and, in many cases, death, because there is no limit to its effects.

Coca paste addicts, fighting the central nervous system depression, or crash, end a run with alcohol, generally beer. They suffer chronic constipation.

Coca paste is laughably cheap; enough for one smoke costs 20¢, the price of a loaf of bread. At one time, paste was masked with tobacco; now it is used on its own, placed in a tin foil pipe, or a wooden pipe called a toco, and ignited.

A few years ago, coca paste smoking was the province of the poor, and cocaine hydrochloride the province of the rich. Now the pattern is democratic; paste addicts are now found in every age, social, and economic group.

Bolivia has one of the lowest per capita incomes in the world. Much of the country was plagued last year by drought, and this year by floods. Typhoid is endemic, infant mortality high, and malnutrition ever-present.

A supreme irony is that coca paste smoking cuts the appetite, and addicts would rather smoke than eat. Hence the walking cadavers.

Dr Noya says when addicts are put into treatment they gain as much as 10 to 20 kilograms in just a few weeks. But they lose weight again when they return to coca paste smoking.

Cocaine is now a billion-dollar-a-year industry, and poor farmers make 10 to 15 times more from coca leaves than they can earn from any other crop. Coca paste is cheap to produce: about $20 a kg. This is one of the reasons Dr Noya fears there will be more and more attempts to smuggle it into North America.

As for the effects cocaine has on Bolivia — aside from coca paste addiction — Dr Noya points to the "town" of Sinaota in the middle of the cocaine-producing area.

'Bolivia has paid dearly for being a producer of coca leaves.'

Noya: protect the children

"In Sinaota, there is no law, no police, no judges. As a kid, I used to see films of the old American west where the gun was law. That is what is happening in Sinaota today, a little town without law.

"People from Santa Cruz and Cochabamba — they're there with beautiful Mercedes Benz and BMWs and trade them with the coca growers. They also trade every sort of electrical goods as well."

During his current visit to the US, Dr Noya searched for funds for fledgling provincial programs in Bolivia.

"All of the programs PRIDE is doing here, we are going to try to do in Bolivia. Already we have received a lot of help from the Lions Club in La Paz."

It is difficult for North Americans to understand how far $1,000 will go in a poor country. "With $1,000, we could set up a complete drug prevention office in Santa Cruz, including salaries," Dr Noya says.

Money could — but won't — be the key to ending coca production.

Dr Noya: "The peasant is interested only in money, not in cocaine. With $50 million you could pay every peasant enough to stop him growing coca. But when you have a $10 billion industry, you have to face reality, and so it won't happen."

Bolivia has paid dearly for being a producer of coca leaves. "There are political and economic pressures trying to make Bolivia, along with Colombia and Peru, the scapegoat for the world's drug problems," Dr Noya declares.

But all he can do is to try and give hope to poor children "and protect them as much as we can.

"We cannot eradicate the problem, but we must try and get some kind of control, because without it, we are lost."

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

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Behavioral research contributes significantly

Cooperative spirit urged

Judging from his demeaning letter in **The Journal**'s April issue, Richard Hickle equates all behavioral-research and treatment with controlled drinking, white rats, and "nickle-and-dime research." Perhaps he is unaware that:

1. Behavioral research has yielded some of the most effective methods available for helping alcoholics to achieve total abstinence.

2. Contrary to Mr Hickle's opinion, behavior therapists historically have been concerned enough about "failure of their theories" to put them to scientific test, rejecting methods found to be ineffective while retaining those with proven results.

3. Virtually *all* alcoholism treatment (Alcoholics Anonymous included) operates by suppressing drinking behavior, thus "treating the symptom" rather than curing a disease. Also, the symptomatic treatment of illness (without curing it) is not at all uncommon practice in medicine — from psychosis to diabetes to the common cold.

4. Many behavior therapists are inclined to recommend abstinence, not moderation, for addicted alcoholics, and (based on the data) view moderation as most promising when used as a preventive strategy with less severe problem drinkers.

5. Alcoholics "die in misery and despair" following unsuccessful treatment of *any* kind, whether the goal was abstinence or moderation. The follow-up of any abstinence program reveals fatalities.

6. Although it is unlikely that Mr Hickle has ever actually counselled a single alcoholic who was unsuccessfully treated in one of the few available, competent, moderation-oriented programs, nevertheless all of us in this field see each other's treatment failures, and an appropriate stance toward one's professional colleagues is a cooperative spirit coupled with a healthy degree of humility.

William R. Miller, PhD
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University of New Mexico
Albuquerque

Tobacco promotion not sporting

I appreciate the coverage given by **The Journal** to issues relating to smoking and health. However, I do want to comment on the March issue of **The Journal**, in particular The Back Page article by Jon Newton entitled, Is it sporting?

Mr Newton has given considerable space to quotes from the tobacco industry, representatives of the Canadian Ski Association, and the parents of athletes. The Canadian Ski Association representatives and athletes argue that the advertisement of tobacco in and around ski slopes does not affect them personally. Whether or not it does affect them, surely the point is that the media coverage of the events has high promotional value for tobacco with viewing and reading audiences.

Greg Hilton, executive director of the Canadian Ski Association, is quoted as saying: "I am not worried about the Horst Bulaus; they are experienced people who have already been through the grind. I am talking about the nine- and 10-year-olds who were confronted over the weekend. There was no brand identification with Macdonald whatever — yet these anti-smoking groups asked the athletes to wear buttons and things. That's dirty pool."

If you turn **The Journal** over to the front page, you will see an illustration of a sign advertising the RJR-Macdonald symbol in association with athletics. Clearly, the skiing events in question, and the athletes, are identified with the Export "A" symbolism. No effort was taken by the health organizations, however, as was suggested by Mr Hilton, to influence athletes to carry non-smoking materials. He is trying to obscure the issue of tobacco promotion.

Mr Hilton makes an allegation that members of the health community were phoning athletes to get their support against the tobacco industry. This is false information. No attempts were made by those from the health organizations involved to reach the athletes.

Clearly, the main concern about the tobacco sponsorship of amateur sporting events is that a product that kills 30,000 people a year in Canada should not be promoted on the backs of young people, particularly those who are involved in amateur athletics. I personally was in Thunder Bay at the opening of the event and was astounded at the extent to which there was blatant and full publicity by the tobacco company on road signs on the way to the ski slope, in the ski chalet, and on the slope.

Ski officials wore tags around their necks carrying the Export "A" insignia; there was an Export "A" banner at the starting gate, an Export "A" banner at the top of the ski jump, and Export "A" banners all around the ski slope; there were Export "A" flags and posters; bibs on the skiers in the same color, with the same lettering as the Export "A" posters and signs; Export "A" signs on the winners' podium and, of course, the Export "A" cup.

It would have taken a very skilled television cameraman indeed to find a camera angle that could avoid including the Export "A" insignia of one kind or another. This was proved to be the case when the television programs were viewed at home the week following the event.

In my view, the article has slanted coverage in an unfortunate direction giving credence to the rationalization of the tobacco industry and a very defensive Canadian Ski Association.

David Nostbakken, PhD
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Canadian Cancer Society
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Cabin fever taking over

Help! Living here in British Columbia, on the edge of the civilized world, I am heavily dependent on The Journal for news of my field. But I can't seem to get a subscription mailed to me. Cabin fever gets pretty bad when The Journal doesn't arrive each month.

I wrote a few months ago to complain, and sent another $12 in case I had forgotten to pay. Evidently I hadn't forgotten — I received a $12 refund, a friendly letter, and three back issues I had requested. But I've received no new issues since then.

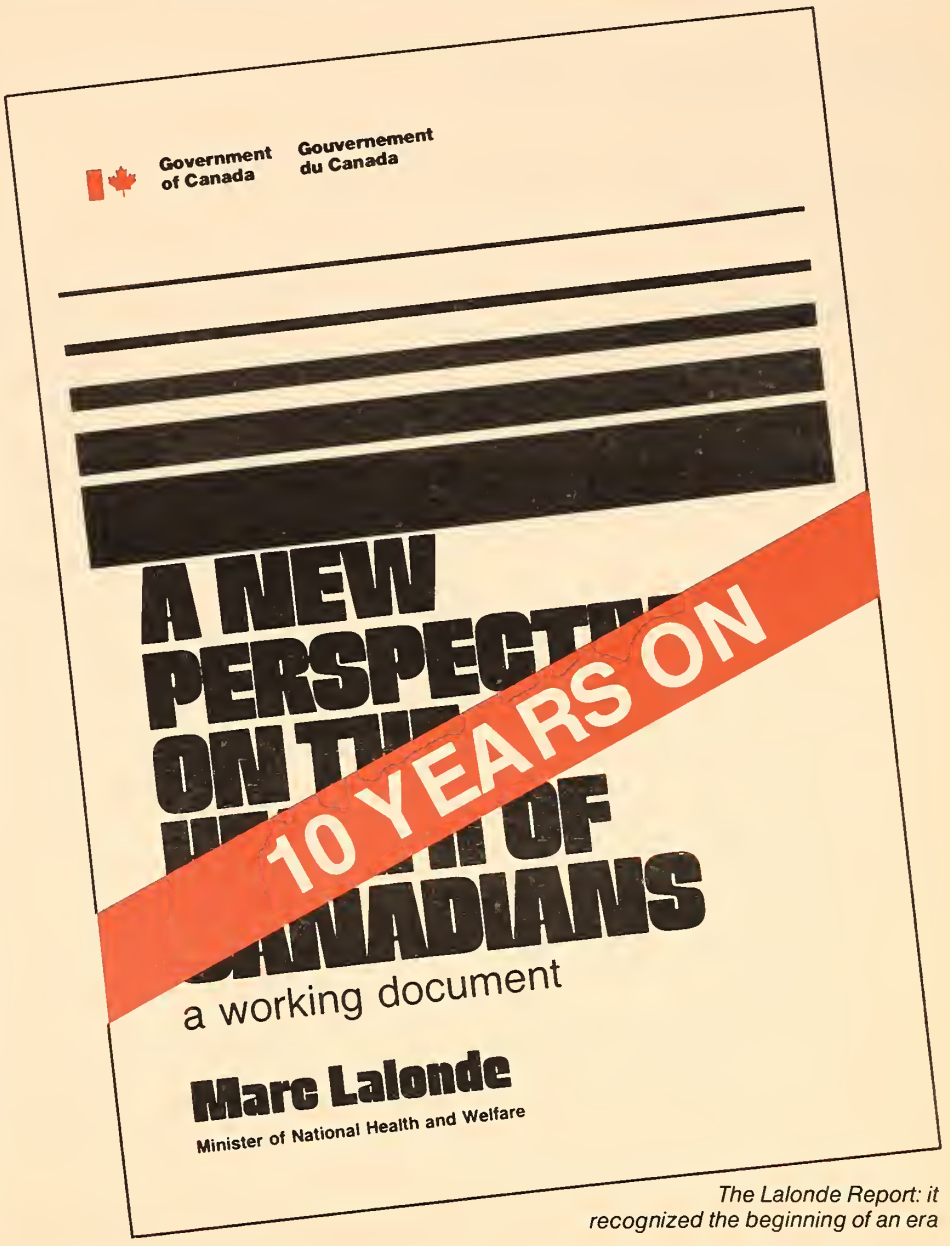
Could you please arrange for me to receive the February, March, and April issues, and subsequent issues each month?

Bruce K. Alexander, PhD
Professor
Department of Psychology
Simon Fraser University
Burnaby, BC

***Editor's note:** Relief is on the way.*

Newer perspectives on the health of Canadians:

Beyond the Lalonde Report



The Lalonde Report: it recognized the beginning of an era

By Milton Terris, MD, MPH*

In April 1974, the Government of Canada published a remarkable document, *A New Perspective on the Health of Canadians/Nouvelle Perspective de la Santé des Canadiens*, written by Marc Lalonde, then Minister of National Health and Welfare.

This was an achievement of which both French and English Canada can be very proud. Brilliantly conceived, and written with the clarity and elegance that we associate with the French literary tradition, the Lalonde Report was and remains one of the great achievements of the modern public health movement. It is, to use the current vernacular, a "world-class" document.

The Lalonde Report was the first official government statement of policy that recognized the beginning of a new era in public health, the era of the second epidemiologic revolution which, just as the first epidemiologic revolution conquered infectious diseases, will, during the next few decades, achieve the conquest of some of the most important noninfectious diseases.

The Report not only proclaimed this recognition to the world at large, but did so within the framework of an overall philosophical outlook which provided the conceptual basis for analyzing health problems and for charting the approaches needed for their solution. It is to the great credit of the Lalonde Report that it did not stop at the conceptual level but actually delineated the specific measures that can be taken. The Report is therefore not only a major contribution to public health theory, but an indispensable guide to action.

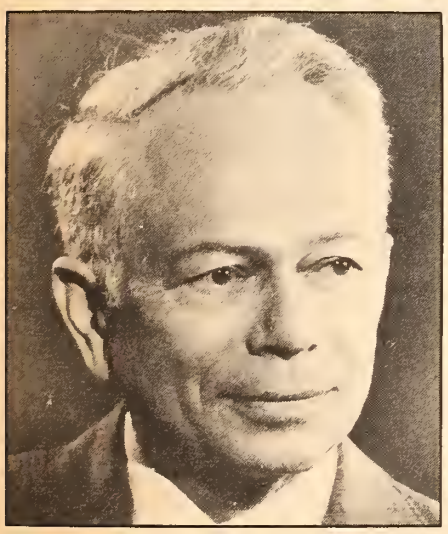
A modern philosopher has aptly stated that "theory is the eye of practice." The Lalonde Report saw further and more clearly than did the practitioners of public health, bound as they were by the limitations imposed by their daily tasks. The Report illuminates the road ahead; it provides the vision which public health workers need to create what will undoubtedly be a new Golden Age of public health practice.

The essence of the Lalonde Report is the Health Field Concept. The Report states:

"A basic problem in analyzing the health field has been the absence of an agreed conceptual framework for sub-dividing it into its principal elements. Without such a framework, it has been difficult to communicate properly or to break up the field into manageable segments which are amenable to analysis and evaluation. It was felt keenly that there was a need to organize the thousands of pieces into an orderly pattern that was both intellectually acceptable and sufficiently simple to permit a quick location, in the pattern, of almost any idea, problem or activity related to health: a sort of map of the health territory.

Such a Health Field Concept has developed during the preparation of this paper and it envisages that the health field can be broken up into four broad elements: human biology, environment, lifestyle, and health care organization. These four elements were identified through an examination of the causes and underlying factors of sickness and death in Canada, and from an assessment of the parts the elements play in affecting the level of health in Canada . . .

Until now most of society's efforts to improve health, and the bulk of direct health expenditures, have been focused on the health care organization. Yet, when we identify the present main causes of sickness and death in Canada, we find that they are rooted in the other three elements of the concept: human biology, environment, and lifestyle. It is apparent, therefore, that vast sums are being spent treating diseases that could have been prevented in the first place. Greater attention to the first three conceptual elements is needed if we are to continue to reduce disability and early death."



** Dr Terris is Rosenstadt Professor, department of preventive medicine and biostatistics, Division of Community Health, Faculty of Medicine, University of Toronto. In this special two-page report,* **The Journal** *presents the Rosenstadt lecture, delivered by Dr Terris at the University of Toronto in April.*

Founder and editor of the Journal of Public Health Policy, Dr Terris is also founder and president in the United States of both the National Association for Public Health and the Public Health Political Action Committee. He was also the founder in 1967, and president until 1969, of the Society for Epidemiologic Research; and founder in 1973, and president until 1980, of the Hermann Biggs Society.

He is considered by many to be the father of public health in North America.

Based on the Health Field Concept, the Report proposed five strategies:

"1. A **Health Promotion Strategy** aimed at informing, influencing, and assisting both individuals and organizations so that they will accept more responsibility and be more active in matters affecting mental and physical health.
2. A **Regulatory Strategy** aimed at using federal regulatory powers to reduce hazards to mental and physical health, and at encouraging and assisting provinces to use their regulatory powers to the same end.
3. A **Research Strategy** designed to help discover and apply knowledge needed to solve mental and physical health problems.
4. A **Health Care Efficiency Strategy** the objective of which shall be to help the provinces reorganize the system for delivering mental and physical health care so that the three elements of cost, accessibility, and effectiveness are balanced in the interest of Canadians.
5. A **Goal-Setting Strategy** the purpose of which will be to set, in cooperation with others, goals for raising the level of the mental and physical health of Canadians and improving the efficiency of the health care system."

Not only were these general strategies proposed, but the Report listed "some possible courses of action" for each of the strategies. A total of 67 specific actions were listed for the four content strategies; for the **Goal-Setting Strategy** the following were listed:

"68. The development of specific reductions in the incidence of major mortality and morbidity.
69. The establishment of specific dates by which reductions in mortality and morbidity are to be achieved.
70. The development of specific improvements in the efficiency of the health care delivery system, including improvements in cost performance, accessibility of care, and the effectiveness of results.
71. The establishment of specific dates by which improvements are to be achieved.
72. The setting of standards of care in both mental and physical health care systems.
73. The extension of national standards of nutrition to include definite recommendations on safe levels of intake for hazardous substances occurring naturally in food.
74. A renewed commitment toward the health goals of the World Health Organization and the Pan American Health Organization."

Goal-setting in the US

I have given special emphasis to the **Goal-Setting Strategy** because, as a citizen of the United States, I am proud to state that my country has been the first to adopt several of these recommendations of the Lalonde Report, namely, items 68, 69, and 73. A new era in health planning, instituting a profoundly revolutionary change from almost exclusive concern with health resources to a primary emphasis on *health outcomes*, occurred in July 1979, when Dr Julius B. Richmond submitted the first *Surgeon General's Report on Health Promotion and Disease Prevention.*

That report, *Healthy People*, reviewed present preventable threats to health, and identified 15 priority areas in which, with appropriate actions, further gains can be expected over the decade. The report established broad national goals — expressed as reductions in overall death rates or days of disability — for the improvement of the health of Americans at the five major life stages. Specifically, the goals established were:

- To continue to improve infant health, and, by 1990, to reduce infant mortality by at least 35%, to fewer than nine deaths per 1,000 live births.
- To improve child health, foster optimal childhood development, and, by 1990, to reduce deaths among children ages one to 14 years by at least 20%, to fewer than 34 per 100,000.
- To improve the health and health habits of adolescents and young adults, and, by 1990, to reduce deaths among people ages 15 to 24 by at least 20%, to fewer than 93 per 100,000.
- To improve the health of adults, and, by 1990, to reduce deaths among people ages 25 to 64 by at least 25% to fewer than 400 per 100,000.
- To improve the health and quality of life for older adults and, by 1990, to reduce the average annual number of days of restricted activity due to acute and chronic conditions by 20%, to fewer than 30 days per year for people aged 65 and older.

In the Fall of 1980, the Surgeon General issued a second report, *Promoting Health/Preventing Disease: Objectives for the Nation*, which established specific and quantifiable objectives necessary for the attainment of these broad goals. Objectives were established for each of the 15 priority areas identified in the Surgeon General's report: high blood pressure control; family planning; pregnancy and infant health; immunization; sexually transmitted diseases; toxic agent control; occupational safety and health; accident prevention and injury control; fluoridation and dental health; surveillance and control of infectious diseases; smoking and health; misuse of alcohol and drugs; nutrition; physical fitness and exercise; and control of stress and violent behavior.

For each of the 15 areas, specific national objectives were defined for these five categories:

1. Improved health status.
2. Reduced risk factors.
3. Improved public and professional awareness.
4. Improved services and protection.
5. Improved surveillance and evaluation.

Let me present some of the health status or outcome objectives to indicate their concreteness and specificity with regard to both quantity and time:

By 1990, the national infant mortality rate, which was 13.8 deaths per 1,000 live births in 1978, should be reduced to no more than nine deaths per 1,000; the neonatal death rate, which was 9.5 deaths per 1,000 live births in 1978, should be reduced to no more than 6.5 deaths per 1,000; and the perinatal death rate, which was 15.4 deaths per 1,000 live births and late fetal deaths in 1977, should be reduced to no more than 5.5 deaths per 1,000.

The reported annual incidence of those infectious diseases which are preventable by

Newer perspectives on the health of Canadians:

Beyond the Lalonde Report

(from page 9)

Annual Number of Cases

	1979	Maximum Number by 1990
Measles	13,597	<500
Mumps	14,225	<1,000
Rubella	11,795	<1,000
Congenital Rubella Syndrome	62	<10
Diphtheria	59	<500
Pertussis	1,617	<1,000
Tetanus	81	<50
Poliomyelitis	26	<10

Similar objectives were stated for other infectious diseases, a number of which are indicated below:

Incidence per 100,000 Population

	1978	By 1990
Tuberculosis	13.1	8
Hepatitis B	45	20
Pneumococcal Pneumonia	182	115
Bacterial meningitis	8.2	6

At the present time, *Public Health Reports* is publishing current reports on progress toward achieving the 1990 objectives: surveillance and control of infectious diseases, in May-June 1983; occupational safety and health, in July-August 1983; immunization, and alcohol and drug misuse, in September-October, 1983. A supplement to the September-October 1983 issue has also been published, *Promoting Health/Preventing Disease: Public Health Service Implementation Plans for Attaining the Objectives for the Nation.*

It is still too early to evaluate the progress made. For diseases preventable by immunization in childhood, progress has been more apparent: the targets for diphtheria, paralytic poliomyelitis, and congenital rubella syndrome have already been met. Large reductions have already occurred for mumps, rubella, and measles, but there has been no reduction in pertussis incidence. For other infectious diseases, such as hepatitis B, pneumococcal pneumonia, and bacterial meningitis, no reductions in incidence have yet been reported. For tuberculosis, there were 13.1 cases per 100,000 population in 1978, the target was eight, and the provisional 1982 figure was 11.9. But, as the report noted: "From 1968 through 1978, the incidence of tuberculosis declined about 6% per year. From 1979 through 1981, however, the decline slipped to only 3% per year."

The current reports on progress toward the 1990 objectives for occupational safety and health and for alcohol and drug misuse appear to present primarily activities rather than accomplishments.

Whether the US will reach the 1990 objectives is problematical. Immediately on taking office in 1980, President Reagan and his Republican and Democratic supporters in the Congress instituted a 25% reduction (actually 35% because of inflation) in federal aid to the states for preventive health programs and other community health services. Drastic cuts have been made in the budgets of the Environmental Protection Agency, the Occupational Safety and Health Administration, the Centers for Disease Control, the Smoking and Health program, and the Consumer Product Safety Commission. Major reductions have been made in school lunch, food stamps, the WIC (Women, Infants and Children) program, nutrition education, and other nutrition services. Serious cuts have been made in Medicaid, Medicare, and the National Health Service Corps, as well as in health professions education, including biostatistics, epidemiology, health administration, mental health, and occupational and environmental health. Further cuts in health services have been promised if Ronald Reagan wins the 1984 election.

There is a lesson to be learned from this experience. The conservative and reactionary forces in Great Britain have deliberately undermined the British National Health Service and encouraged the re-privatization of medical care. The conservative and reactionary forces in the United States have undermined and will, if re-elected this year, move to destroy the public health programs which have been built with so much effort and dedication over the past 50 years. They are also determined to dismember our Medicare program of national health insurance for the aged and turn it over to the private insurance companies.

In Canada, the reactionary forces have openly declared their purpose to undermine the national health insurance system and then destroy it. The tendency of Canadian public health workers to underestimate this negative trend is understandable to those of us who have been through the American and British experience; after all, we too did not expect that much would change. Living in Canada today, I find myself subject to a *déjà vu* phenomenon; I seem to have seen it all before, a few hundred miles to the south, in the period before 1980.

Canada's Health Status

It is my hope, nevertheless, that Canada will be spared such a return to the past, and that public health workers will be able to move forward, with full political support, to achieve the goal of better health for all Canadians.

Canada today enjoys a relatively high level of health. During the past decade, significant improvement occurred; as Table 1 indicates, overall age-standardized mortality declined by about 12% during the 1970s. There also occurred about a 25% decline both in ischemic heart disease and cerebrovascular disease during this period. This is approximately equivalent to the decline in the age-adjusted mortality rate for ischemic heart disease during the same period in the United States. It is less steep, however, than the approximately 35% decline in cerebrovascular disease in the United States, a difference that probably reflects the impact of the relatively modest but effective campaign for hypertension control which was led by the US Public Health Service in the 70s.

Unlike other cancer sites, cancer of the lung continues to rise in Canada, and alarmingly so in women, for whom the rate doubled in nine years. Chronic obstructive lung disease, another major killer caused primarily by cigarette smoking, is also on the rise in women. And cirrhosis of the liver, the result primarily of heavy alcohol consumption, increased by 31% in men and 21% in women during the 70s. Deaths from non-natural causes — accidents, poisoning, suicide, and homicide — have shown little change, but continue to occur at a very high level.

All of these diseases are preventable. Ten years after the publication of the Lalonde Report is long enough to wait before decisive action is taken. It would be "a consummation devoutly to be wished" if Canada were to act now to set the goals called for in the Lalonde Report, including the following objectives for major causes of death, disability, and illness. Canada might well adopt as its goal, that **by the year 2000**, mortality will be reduced for:

Ischemic Heart Disease	by 70%
Cerebrovascular Disease	by 70%
Cancer	by 15%
Chronic Obstructive Lung Disease	by 20%
Accidents, Poisoning, Violence	by 30%
Cirrhosis of the Liver	by 40%

These goals are achievable. Even without a concerted public health campaign, age-adjusted mortality from ischemic heart disease and cerebrovascular disease declined by 25% in nine years. The other goals are modest enough; even a 40% decline in the cirrhosis death rate would bring Canada down only to the level of the 14 per 100,000 rate in the US, still far away from the four per 100,000 rate in the United Kingdom.

The proposed goals for mortality are not limited to this parameter; they hold also for morbidity, that is, for illness and disability as well as for death. The approximately 25% decline in age-adjusted mortality for cerebrovascular disease did not result from improvements in the treatment of cerebrovascular disease from 1970 to 1979, for no such improvements occurred. Clearly the cause of the decline was increased public and professional awareness resulting in better case-finding for hypertension, the increased use of antihypertensive drugs, and the more effective maintenance of hypertension treatment and control. This was **primary prevention** of cerebrovascular disease; not only mortality was affected but incidence as well.

Similarly, primary prevention was mainly responsible for the approximately 25% decline in age-adjusted mortality for ischemic heart disease in the 1970s. In view of the fact that 60% to 67% of deaths from myocardial infarction occur outside of hospital, while improvements in medical and surgical therapy have been shown to exert only a moderate effect on survivorship, treatment cannot be considered to have played a major role in the decline. On the contrary, all of the evidence points to risk-factor changes as the most important factor in this unprecedented reduction.

During the coming period, we shall lower mortality not only from cerebrovascular disease and ischemic heart disease, but from accidents, poisoning, and violence; from lung and other cancers caused by tobacco, alcohol, and other environmental and occupational carcinogens; from cirrhosis of the liver; and from chronic lung disease caused by cigarette smoking and by the occupational exposures of miners, textile workers, grain workers, and others exposed to harmful dusts. We shall also be effective in reducing mortality from a variety of other diseases caused by toxic chemicals and other environmental and occupational hazards. These victories will be accomplished by **primary prevention**, by methods which, unlike medical care, **reduce incidence** as well as mortality. We shall also make effective use of screening programs to discover cervical and breast cancer in the presymptomatic stage, thereby also preventing illness as well as mortality.

To implement the program to prevent these major causes of illness, disability, and death will require a sustained and well-funded campaign, led by Canada's local, provincial, and national health departments. "Well-funded" in this case requires only a small fraction of the many billions of dollars which Canada now spends for the treatment of these preventable diseases. And the guidelines are already available; they have been outlined in the Lalonde Report, with its emphasis on both health education and regulatory approaches.

Implementation of this program is not only a question of achieving a higher level of health for the Canadian people, but for achieving *equity* in health. Just as the Canadian national health insurance program was established to assure equity in medical care, so must this aim be pursued in the more fundamental goal of improving health status. The available evidence indicates that both in the US and Canada, lifestyle modification has been more effective in the more highly educated groups. Table 2 is strikingly illustrative of this fact; smoking cessation has occurred primarily among the most highly educated. It is essential, therefore, that every effort be made to reach the less highly educated groups that comprise the majority of the Canadian population in order to make certain that the World Health Organization's Alma-Ata pledge of "Health for All by the Year 2000," to which Canada is a signatory nation, is indeed fulfilled for all the people of Canada.

I should like to propose, therefore, that the Division of Community Health of the University of Toronto take the initiative by inviting the Ontario Ministry of Health and the local Medical Officers of Health to form a joint exploratory committee. That committee would be well advised to visit Montreal in the near future to meet with representatives of the 32 DSCs, the Départements de Santé Communautaire, who last December organized a major conference to launch a similar program in Quebec. It would be entirely appropriate for Quebec and Ontario — for French Canada and the most populous province of English Canada —then to call jointly for a national conference of all the provinces with the Department of National Health and Welfare, in order to plan a nationwide program to implement the goal of "Better Health for All Canadians." This initiative will surely be welcomed by the provinces, a number of which are now in the unenviable position of appearing to be more interested in protecting the doctors' pocketbooks than in protecting the health of the public.

Ten years is long enough to wait for decisive steps to implement the Lalonde Report. Let us celebrate the 10th anniversary of this remarkable Canadian document by starting such action now. In doing so, we shall honor our commitment as public health workers. We shall save millions of Canadians from unnecessary illness, disability, and death. We shall help fulfill the promise of better health and a better life for all Canadians.

Table 2 Prevalence of Regular Cigarette Smokers in Women by Education, Canada, 1977 and 1981.

Education (% of Total Population, 1981)	% Smoking Cigarettes 1977	1981	% Change 1977 to 1981
Elementary (20.9%)	25.4	24.3	— 4
Some Secondary (54%)	34.4	33.5	— 3
Some Post-secondary (7.4%)	28.7	26.3	— 8
Post-secondary Certificate/Diploma (11.1%)	32.6	24.5	—25
University Degree (6.5%)	26.3	15.5	—41
All Women (100%)	31.1	28.9	— 7

Source: Adapted by M.J. Ashley from *Health and Welfare Canada*, 1979, 1983.

Table 1 Age-Standardized Mortality Rates (ages 25-74), Canada, 1970-1979.

Cause of Death	Sex	1970	1979	% Change, 1970-79
All Causes	M	1022.9	920.0	—10.1
	F	534.4	458.9	—14.1
Ischemic Heart Disease	M	379.0	299.6	—20.9
	F	131.4	97.1	—26.1
Cerebrovascular Disease	M	65.9	49.7	—24.6
	F	49.9	36.6	—27.9
All Cancer	M	230.3	241.8	+ 5.0
	F	173.4	170.2	— 1.8
Lung Cancer	M	71.3	86.5	+ 21.3
	F	11.5	22.9	+ 99.1
Chronic Obstructive Lung Disease (bronchitis, emphysema, asthma)	M	33.9	30.2	—10.9
	F	8.1	9.6	+ 18.5
Non-natural Causes (accidents, poisoning, violence)	M	111.1	108.2	— 2.6
	F	40.8	38.1	— 6.6
Cirrhosis of the Liver	M	21.5	28.2	+ 31.2
	F	9.7	11.7	+ 20.6

Source: Health and Welfare Canada. *Chronic Diseases in Canada* 3(2):19-22, September 1982.

Drinking, boating don't mix New Zealanders warned

By Pat McCarthy

AUCKLAND, NZ — Residents of this harbor city, which is built on a narrow isthmus between the Pacific Ocean and the Tasman Sea, own an estimated 70,000 boats — nearly one for every 10 inhabitants. They treat the sea as a playground.

But when they mix drinking with boating, the sea often turns out to be a graveyard. Pathologists at the University of Auckland School of Medicine have established that three-quarters of Aucklanders who died in boating accidents were drunk.

Researchers, led by associate professor Francis J. Cairns, analyzed autopsies on 225 people more than 15 years old who drowned in Auckland over an eight-year period.

At least half of the 129 males and 21 females considered to have drowned accidentally showed evidence of having consumed alcohol, and in 37% of these cases the blood alcohol level was more than 0.10%.

A message from the NZ Alcoholic Liquor Advisory Council

In 22 of the 39 boating fatalities examined, a boat either overturned or was swamped. Eleven other victims fell out of boats, nine of which were moored at the time.

"It is remarkable that in 75% of the boating fatalities and in 50% of the falls (from wharves, into baths and pools, etc) the level of blood alcohol was well in excess of 100 mg per 100 ml blood (0.10%)," the researchers reported in the *New Zealand Medical Journal* (Feb 8).

The fact that the alcohol-related boating accidents and falls occurred in an older age group than did swimming fatalities "indicates the association of alcohol and drowning is not restricted to the young and irresponsible."

Auckland harbor: a dangerous playground for drinkers

The seven drowned females for whom alcohol levels were available had levels above 0.10%. Five died as a result of motor vehicles being driven into water.

The pathologists said some research showed that in certain circumstances even small amounts of alcohol can be dangerous.

They said alcohol depresses the formulation of carbohydrates, so that if people exercise first to utilize the body's carbohydrate stores, consumption of alcohol may produce profound decreases in blood glucose levels. This can cause weakness and confusion, but also can interfere with normal temperature regulating mechanisms.

In some of the Auckland victims, death appeared to be instantaneous, without panic or struggle, and without fluid's being aspirated into lungs or stomach. Mechanisms suggested include a reflex spasm closing the larynx and cutting off oxygen, reflex cardiac arrest, or vasovagal inhibition due to the sudden entry of water into the nose and upper airways.

DC tops US drinks-per-capita list

WASHINGTON — The District of Columbia ranked first-place in per capita alcohol consumption in 1982, according to recent United States estimates of taxable sales of alcoholic beverages.

Nevada, which in 1981 was the leading state in terms of the amount of alcohol consumed, slipped to second spot.

In DC, those more than 14 years old each drank 5.39 gallons of wine, beer, and spirits, while their counterparts in Nevada managed 5.26 gallons per capita.

New Hampshire had the third highest per capita consumption — 4.81 gallons — while Alaska, with 4.05 gallons, and Hawaii, with 3.42 gallons, came fourth and fifth respectively.

The US state with the lowest per capita consumption was Utah with 1.71 gallons. Arkansas, West Virginia, and Alabama ranked 49th, 48th, and 47th respectively.

The figures are from the Alcohol Epidemiologic Data System (AEDS) here, a contract effort of the Division of Biometry and Epidemiology of the US National Institute on Drug Abuse.

However, the AEDS report, *US Apparent Consumption for Calendar Year 1982*, notes "the diversity of the manner in which data are received . . . precludes any systemized statement of alcoholic beverage sales in the US today.

"It should also be noted that sales or revenue collections do not equal consumption in reality. Current estimates are very approximate. . ."

Highest and lowest military ranks drink most

CF personnel drink more often than civilians

OTTAWA — The lowliest privates and the highest ranking officers in the Canadian Forces (CF) have at least one thing in common. They're likely to be the heaviest drinkers, says a recently-published report.

Moreover, almost a quarter of the 6,182 personnel in the study drank three or more times a day, several times a week — "a level commensurate with impaired problem-solving ability, short-term memory, visual spatial coordination, abstract thinking, and the general ability to think straight."

The report is based on a 1982 study * designed to examine chemical use in the Canadian military setting.

Overall, 90% of the study population drank at least once in the month prior to the survey, 56% drank on one or two days a week, 24% on three or four days a week, and 9% on five or more days a week.

People in the Canadian services don't drink as much as their United States counterparts, says the study, but they drink more often (**The Journal**, Oct 1983).

And two profiles of heavy drinkers emerge.

Personnel below officer rank with drinking problems are likely to be young, male, never-married and with English as their first language. They're probably stationed in the Pacific region, and have at least eight drinks every day.

Among officers, the most serious alcohol abusers (also about eight drinks a day) are most probably Lt-Colonels and higher, followed by 1st and 2nd lieutenants, officer cadets, captains, and majors.

Military life: promotes alcohol consumption but discourages drug use

Privates are easily the heaviest drinkers in the non-commissioned ranks, followed by corporals, sergeants, warrant officers, and senior warrant officers.

As well, states the report, senior officers "arbitrarily defined as Lt-Col and higher, show an inordinately heavy consumption, exceeded only by privates. Still, other ranks are, in general, more frequent drinkers than officers."

But, "highest rates of drinking are found among officers in Sea Ops (operations) . . . and among the higher-ranking officers."

The study estimates that 11% of all Canadian Forces members have an average of five or more drinks a day and that, overall, they appear to drink more often than the national average, although "quantities of intake" among CF members are somewhat lower, especially among males.

As for drugs, cannabis came top of the list as the most frequently used illicit substance, followed by other hallucinogens, amphetamines/uppers, cocaine, tranquillizers/downers, PCP (phencyclidine), other opiates, solvents, and heroin.

Surprisingly, more women than men used cannabis — marijuana and hashish. Rate of use was also highest among francophones, those raised in central Canada, "those of more moderate" educational levels, and personnel stationed in the eastern region or overseas.

"Even though 14% reported use of cannabis at least once during the past year," says the report, "the frequency of such use was low with 5% using it only once, and an additional 3% using it three to 11 times."

And 60% of personnel who said they had used illicit drugs during the year prior to the survey showed a concomitant use of alcohol.

More service personnel drink than use drugs, the report continues, but substance abuse (other than alcohol) does not seem to be serious compared to national averages.

"Military life seems to promote the consumption of alcohol" and "tends to discourage the use of drugs, especially for those who see the CF as a vocation."

The report concludes that:

- higher-than-average rates of alcohol and/or drug use are attributable to the effects of the military setting; and
- higher-than-average rates of alcohol and/or drug use are attributable to the effects of the wider social context of experience (both past and present) which members of the CF bring to their life in the military.

The report urges that "educational programs be directed to the general CF population (**The Journal**, March), rather than directly toward users (either of alcohol or drugs). The prevailing attitudes in the military seem to affect users through peer pressure and informal sanctions."

* *The Use of Alcohol and Illicit Drugs Among Members of the Canadian Forces*. Directorate of Preventive Medicine, National Defence HQ, Ottawa K1A 0K2.

Teens prefer hard-hitting DWI slogan

TORONTO — Teens believe hard-hitting messages are more effective than the "velvet-glove" approach in anti-drinking and driving campaigns.

This is suggested in a survey of students of five high schools in the City of North York near here.

The students were asked to evaluate two posters prepared by the Insurance Bureau of Canada (IBC). One uses a dramatic photograph of an accident and the caption: "A lot of teens had fun this weekend. A lot didn't." The second has a less dramatic photo and the message: "Before you ride make sure you know who is in the driver's seat."

Of the 1,276 students surveyed, 51% selected the first approach as the most effective; 18% chose the second message; and 31% expressed no choice.

Many of the students said they preferred the tougher line because of the dramatic photograph; some believed an even more sensational photograph was warranted.

The posters, part of the IBC's three-year campaign against drinking and driving (The Journal, Nov 1983), will be distributed to schools throughout Canada. The survey was conducted by North York Mayor Mel Lastman's Advisory Committee on Drinking and Driving.

Poster: tougher line

NEWS AND COMMENT

Windsurfing: battle in the wind

Tobacco sponsor in windsurfer row

TORONTO — The RJR-Macdonald tobacco company, still attempting to salvage its Export "A" sponsorship of the Canadian Ski Association's (CSA) amateur events, is at war again, this time over its proposed backing of windsurfing competitions scheduled for the Canada Day weekend in July.

Macdonald has been embroiled in a bitter argument between the CSA and the federal government over the company's five-year, $1.7 million commitment to the skiing contests (**The Journal**, April, March). Currently, the federal government contributes $2.5 million annually to the CSA.

Health Minister Monique Begin and Fitness and Amateur Sport Minister Jacques Olivier believe Macdonald's involvement threatens their stance "that the government cannot support a sponsorship that associates skiing and smoking." They remain adamant that the tobacco company shall not be permitted to continue its association with the CSA.

But Macdonald and the CSA seem equally determined to maintain their relationship, although it would also appear that the ski group's enthusiasm is diminishing as the negotiations continue in deadlock.

The latest battle is around Macdonald's proposed sponsorship of the Canadian Windsurfer Class Association contests at Ward Island here on Canada Day weekend. These were to have led up to the world championships, as well as providing an opportunity for would-be entrants in an Olympic board-sailing exhibition. The association has no government funding and depends on outside sponsorship.

Last month, Toronto City Council decided to pass the question as to whether Macdonald will be allowed to participate to Metro Toronto's Neighborhoods Committee.

Olivier

Begin

That committee, in turn, passed it back to the City Council for further consideration at the end of April.

At the meeting were representatives of the Non-Smokers Rights Association, the Ontario Heart Foundation, the Canadian Cancer Society, and the Ontario Lung Association, as well as Jeff Goodman, director of public relations and public affairs for Macdonald.

It appeared chances of the City's making a favorable recommendation are slim and it is very likely the windsurfing competitions will have to shift to another venue.

Meanwhile, the CSA, Macdonald, and Ministers Begin and Olivier finally managed at the end of April, after three months of cancellations, to discuss the skiing sponsorship.

"No comment" was the response from all three sides after their meeting. But it is understood that the CSA will take the question to their annual general meeting in Saskatoon next month. It is also understood an unofficial CSA poll as to whether the association should continue with Macdonald met with an 80% "Yes."

But, Mr Goodman has already told **The Journal** that if the government forces the issue, his company would indeed allow the CSA to withdraw.

If, however, Macdonald and the skiers dig their heels in, it is almost certain that Ms Begin and Mr Olivier will reluctantly resort to their final weapon — cutting off the federal government's support.

GILBERT

'Cigarette consumption fell in 1982 and 1983 because of high taxation not because of efforts to curb smoking.'

The tobacco industry is right

By Richard Gilbert

The comment in the title applies to an interchange reported in **The Journal** in March. Federal Health Minister Monique Begin attributed the substantial fall in cigarette sales in Canada in 1983 to her department's smoking cessation programs. Jacques LaRivière of the Canadian Tobacco Manufacturers' Council blamed "the dramatic increase in taxation." Mr LaRivière was right, although I should add that the work of Ms Begin's department may have contributed to the political climate that made large tax increases possible.

I reported on the relationship between per capita cigarette consumption and the price of cigarettes in my April 1982 column. There I presented a graph that showed an almost relentless increase in consumption — from an average of 1,252 cigarettes bought by each Canadian in 1949 to 2,739 (since revised to 2,682) in 1980. The mean annual increase was 2.5%. The only significant interruption of the increase occurred between 1966 and 1969, which also corresponded to the only major increase in real price between 1949 and 1980.

The conclusion I drew from the data for the period 1949 to 1980 was that consumption varied with price such that a 1.0% change in real price (ie, actual price adjusted for inflation) produced a 0.7% change in consumption, in the opposite direction. Econometricians would say that the short-term, real price elasticity of demand over the period was -0.7.

Sufficient cause

Table 1 shows what has been happening since 1979, which can now be seen as the last year of almost uninterrupted increases in consumption. (The data in this table are susceptible to revision because of their recency.)

What should be noted here is that in each of the last two years, when consumption had clearly begun to decline, the fall in consumption was less in relation to the increases in real price than would have been predicted from the period 1949 to 1980. The 4.0% price increase between 1981 and 1982 should, on the basis of the 1949 to 1980 data, have led to a 2.8% decline in consumption. The actual fall was 1.5%. The 11.6% increase between 1982 and 1983 should have led to an 8.1% decline in consumption. The actual fall was 5.9%.

Thus the price increases were, on the basis of previous data, more than sufficient to cause the declines in consumption. Accordingly, it is reasonable to suppose that the reduced sales of cigarettes in 1982 and 1983 were in large part, if not entirely, the result of retail price increases in those years. To the extent that retail price increases caused increases in federal and provincial taxes, it must be concluded that the tobacco industry is right: cigarette consumption fell in 1982 and 1983 because of high taxation, not because of efforts to curb smoking.

Table 2 shows how taxes on cigarettes have changed in Canada during the past decade. Three points to note are:

1. The large differences among jurisdictions. Historically, Newfoundland has had the highest rate. The tax there in each year has been a little less than twice the next highest provincial level and more than twice the average level. Currently, a pack of 20 there costs an average of $2.50, which includes the general retail sales tax as well as the tobacco tax. The average price of the same pack in Alberta is $1.40. (The tax rates in the table include the retail sales tax, where charged on cigarettes, in addition to the tobacco tax — ie, in Newfoundland, Prince Edward Island, and, since May 1983, in Ontario.)

2. Overall, taxes on cigarettes did not keep pace with inflation during the period 1974 to 1981. They have increased at a rate substantially above inflation since 1981.

3. In 1974, the larger part of the tax on cigarettes was levied by the federal government (except in Newfoundland). Then, the federal rate was more than two-and-a-half times the average provincial and territorial rate. Now the latter rate is 23% more than the federal rate. Indeed, over the whole decade, the federal rate declined in real terms by 22%.

Furious lobbying

The tobacco industry is lobbying provincial governments furiously to put a halt to, and even reverse, the current escalation in their taxes on tobacco. In January this year, Ontario treasurer Larry Grossman announced that he is having second thoughts about at least one aspect of the tax increases — the levying of retail sales tax on top of the tobacco tax. The sales tax effectively raises Ontario's take from each pack of cigarettes to 52% from 45% of the average retail price.

Last July, at the 5th World Conference on Smoking and Health, Ms Begin said she would seek an increase in the federal tobacco tax that would raise retail prices by 30% (**The Journal**, Aug 1983). In 1983, this would have meant an increase in the federal tax on a pack of 20 to 85 cents from 40 cents, ie, by 113%. The overall increase in the real tax rate from 1974 to 1984 would have been 67%. This would have been considerably less than the increase in the average provincial tax rate over the same period, which, as I noted above, was more than 150%.

Early in 1982, the Ontario Council of Health's Task Force on Smoking recommended increases in taxes on tobacco that would have the result of doubling the price of a pack of cigarettes, and, consequently, halving the rate of consumption (**The Journal**, April 1982). Wittingly or not, the provincial governments seem to be following this advice, while the federal government, notwithstanding Ms Begin's mid-summer statement, still pins its hopes on persuasion as a means of reducing the amount of smoking.

Irony

However, the main motivation of the provincial governments is probably not so much a desire to reduce smoking as a need to increase revenue. As long as a given percentage increase in cigarette price results in a smaller percentage decrease in consumption (ie, the elasticity remains between zero and -1.0), tax increases will always produce gains for government coffers.

What permits governments to increase revenue in this way is ultimately the growth of negative public attitudes toward smoking. The federal Health and Welfare department has made a major contribution to this change in attitude. Ironically, it has been the provincial governments that have reaped the financial benefits.

Table 1: Canadian cigarette consumption, price per pack of 20 cigarettes in 1983 dollars, and changes, 1979-1981.

Year	Per capita cigarette consumption	Percentage change in consumption	Average price per pack of cigarettes (1983$)	Percentage change in real price
1979	2,689	+2.6	$1.30	- 3.4
1980	2,682	- 0.3	$1.29	- 0.8
1981	2,734	+1.9	$1.30	+0.8
1982	2,693	- 1.5	$1.35	+4.0
1983	2,535	- 5.9	$1.51	+11.6

(Based on data from Statistics Canada.)

Table 2: Taxes on cigarettes in 1983 cents, and changes — Canada, provinces, and territories, April 1974, April 1981, and March 1984.

	Tax levied per pack of 20 cigarettes (1983 cents)			Average percentage change in real tax per year	
	1974	1981	1984	1974-81	1981-84
Jurisdiction:					
British Columbia	13	32	43	+13.1	+10.6
Alberta	13	7	29	- 8.6	+59.6
Saskatchewan	16	30	40	+10.1	+9.5
Manitoba	27	28	40	+0.8	+12.4
Ontario	20	28	60	+5.0	+28.7
Quebec	18	35	44	+10.2	+7.6
New Brunswick	18	23	56	+4.0	+33.8
Nova Scotia	18	23	27	+4.0	+4.4
Prince Edward I.	18	34	40	+9.7	+5.6
Newfoundland	51	61	113	+2.5	+23.0
NW Territories	13	28	40	+11.3	+12.4
Yukon	0	38	30		- 6.6
Average prov/terr tax rate (weighted)	19	29	49	+6.6	+18.9
Federal tax	51	34	40	- 5.6	+5.6
Combined tax	70	63	89	- 1.3	+12.1

(Based on information supplied by the Canadian Tobacco Manufacturers' Association and the Canadian Tax Foundation.)

DEPARTMENT

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. For further information, contact Margaret Sheppard at (416) 595-6150.

Beware: The Gaps in Medical Care for Older People

Number: 598.
Subject heading: Drugs and the elderly.
Details: 20 min, 16 mm, video, color.
Synopsis: Beatrice, 78, lives alone. She is depressed and confused to the point where she does not recognize her own house. After a fall she is hospitalized, and later goes to live with her daughter. Problems arise when she cannot open a pill bottle and has difficulty remembering. Her daughter tries, unsuccessfully, to find a specialist in geriatrics. One day, Beatrice is found on the kitchen floor, screaming and hallucinating. At the hospital a geriatrician diagnoses the problem as over-medication and multiple drug use. Beatrice is helped with appropriate medical, physical, and social supports. She is then able to return to living on her own and leading an independent life.
General evaluation: Good (4.3). This well-produced film is a good teaching aid, and promotes better understanding of over-medication, multiple drug use, and the elderly. General broadcast was recommended.
Recommended use: With a resource person this film would be beneficial to families and health professionals working with the elderly.

You've Come a Long Way, Rene

Number: 600.
Subject heading: Smoking.
Details: 22 min, 16 mm, video, color.
Synopsis: Rene, a young black girl, is training for a school track meet. She and her best friend, Carol, are concerned about their weight. Carol smokes cigarettes to keep her weight down, but when she tries to buy a pack, the storekeeper tells her she is too young. Carol tries unsuccessfully to persuade an elderly woman to buy them for her. Eventually, the two girls go to a park with cigarettes that Rene stole from home. Carol and several other girls smoke and are picked up by some boys. Carol ridicules Rene for not being "grown up". However, through a number of real and imagined experiences, Rene comes to believe that smoking is not in her best interest.
General evaluation: Fair to good (3.6). The film had a clear message with humorous sequences. However, the review group took exception to the film's portrayal of the elderly woman as an object of ridicule. The film was judged to take too long to get its message across.
Recommended use: Could be beneficial to teenage girls.

Man Abuses Man

Number: 601.
Subject heading: Drug use: etiology and epidemiology, lifestyles.
Details: 28 min, video, color.
Synopsis: This film states that 70% of all diseases are self-induced: we eat too much, smoke too much, abuse alcohol and other drugs. In spite of tremendous strides in the effectiveness of medications, there has been only a minimal increase in life expectancy. We must restructure our lives to save them.
General evaluation: Poor to fair (2.7). This film tried to cover too much in a short period of time. The constantly shifting emphasis produced a disjointed effect.
Recommended use: General audiences.

Medicine Chest: Time Bomb or Healer?

Number: 602.
Subject heading: Over-the-counter-drugs.
Details: 28 min, video, color.
Synopsis: Every home has a medicine chest, yet few people know what they have in it. Many drugs are out-of-date and no longer safe. People feel that drugs are necessary because they have been bombarded with advertising for many years. However, it is dangerous to keep pills and other kinds of medicines around. It is important to clean out the medicine chest and retain only those few things that are absolutely necessary, such as current prescriptions.
General evaluation: Fair to good (3.6). This well-produced film had a clear message.
Recommended use: With a resource person this film could benefit general audiences.

Dream on Deadly Wings

Number: 603.
Subject heading: Drug use: etiology and epidemiology.
Details: 6 min, color, animation.
Synopsis: A person in an alley is injecting a drug. First come pleasant thoughts and dreams — a flower, a butterfly; then the person has very unpleasant thoughts while coming down from the drug and injects the drug again.
General evaluation: Poor (2.4). Although the animation was well-done, the assessment group believed the film reflected only the negative stereotypes of drug use and had only minimal educational value.
Recommended use: Could be used by audiences 15 years and older, provided a knowledgeable resource person is present to explain other aspects of drug use.

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NEWS AND DEPARTMENT

New Books by RON HALL

Other books

Cannabis and Health Hazards — Fehr, Kevin O'Brien, and Kalant, Harold (eds). Addiction Research Foundation (ARF), Toronto, 1983. Proceedings of an ARF/WHO (World Health Organization) scientific meeting on adverse health and behavioral consequences of cannabis use; clinical toxicology of cannabis use; cannabis, marijuana, and cannabinoid toxicological manifestations in man and animals; effects of marijuana smoke on cellular biochemistry of *in vitro* test systems; interaction of cannabis with arginine metabolism; immunological effects of cannabis; effects of marijuana and cannabinoids on reproduction, endocrine function, development, and chromosomes; acute psychological effects of marijuana in man; chronic effects of cannabis on human brain function and behavior; long-term effects of cannabis on cerebral function; psychiatric effects of cannabis use; tolerance and dependence; epidemiology of cannabis in developing countries and in western countries. Index. 843 p. Addiction Research Foundation, Marketing Services, Dept JR, 33 Russell St, Toronto, ON M5S 2S1. $65. ISBN 0-88868-084-8.

Encyclopedic Handbook of Alcoholism — Pattison, E. Mansell and Kaufman, Edward (eds). Gardner Press, New York, 1982. Definition and diagnosis of alcoholism; biology of alcoholism; medical aspects of alcoholism; social dimensions of alcoholism; psychological perspectives on alcoholism; psychiatric disorders and alcoholism; distinctive treatment populations; alcoholism treatment personnel; alcoholism treatment facilities; alcoholism treatment methods; organization and evaluation of alcoholism treatment systems. Index. 1,230 p. Gardner Press, Inc, 19 Union Square, New York, NY 10003. $79.95. ISBN 0-89867-017-8.

Economics and Alcohol: Consumption and Controls — Grant, Marcus; Plant, Martin; and Williams, Alan (eds). Gardner Press, New York, 1983. Societal costs of alcohol abuse in the United States; calculating the costs of alcohol; costs and benefits of alcohol in Ontario; modelling alcohol consumption and abuse; relationship between taxation, price, and alcohol consumption; economics of alcohol taxation; government policies concerning alcohol taxation; advertising; alcohol and health economics. Index. 302 p. Gardner Press, Inc, 19 Union Square W, New York, NY 10003. ISBN 0-89876-089-5.

Alcohol Problems and Alcohol Control in Europe — Davies, Phil and Walsh, Dermot. Gardner Press, New York, 1983. Public health perspectives on alcohol problems; methodology and data base; alcohol problems and alcohol control in Austria, Belgium, Denmark, France, West Germany, Ireland, Italy, Israel, Luxembourg, the Netherlands, Norway, Poland, Spain, Sweden, Switzerland, the United Kingdom, Europe. Index. Gardner Press, Inc, 19 Union Square W, New York, NY 10003. ISBN 0-89876-090-9.

Message in a Bottle — Dorn, Nicholas and South, Nigel. Gower Publishing, Brookfield, 1983. Theoretical overview and annotated bibliography on the mass media and alcohol; 'effects' models and their variants; commercial, consensual paradigm, and class-culture models. Bibliography. 178 p. Gower Publishing Company, Old Post Rd, Brookfield, VT 05036. $29.95. ISBN 0-566-00621-9.

Adolescent Substance Abuse: A Guide to Prevention and Treatment — Isralowitz, Richard, and Singer, Mark (eds). Haworth Press, New York, 1983. Substance abuse and social deviance, setting the stage for addiction; influences on adolescent problem behavior; reducing black adolescents' drug use; Hispanic adolescents and substance abuse; psychotropic and general drug use by mentally retarded persons; conceptual and clinical issues in the treatment of adolescent alcohol and substance misuses. Index. 123 p. Haworth Press, 28 E 22 St, New York, NY 10010. $19.95. ISBN 0-86656-185-4.

Forbidden Highs — Smart, Reginald G. Addiction Research Foundation, Toronto, 1983. The nature, treatment, and prevention of illicit drug abuse; cannabis use and its problems; heroin and other narcotic drugs; stimulants, cocaine, LSD and other hallucinogens, glue, solvents; efforts at abuse control and prevention. Appendix; references. 244 p. Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1. $12.95. ISBN 0-88868-078-3.

New Books
will return next month

FDA approves nicotine gum marketing

WASHINGTON — The United States Food and Drug Administration (FDA) has given approval for the marketing of nicotine chewing gum which can help smokers kick the habit.

Edward Tocus, PhD, head of the FDA Drug Abuse Section, said the gum is not a panacea, but experiences in Canada, Britain, and Sweden suggest it works with some smokers.

An FDA advisory committee concluded the gum, Nicorette, is effective as an adjunct to a program for modifying smoking behavior (**The Journal**, April 1983, July 1980).

The FDA and manufacturer Merrell Dow Pharmaceuticals caution that the gum should not be used by pregnant or nursing women, those with certain heart conditions, or by non-smokers. They say that under normal use the gum is not expected to be addictive.

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Addictions Extravaganza — May 5-6, Regina, Saskatchewan. Information: Lorri Hovland, Addictions Ex, 728 Broad St N, Regina, SK S4R 7B5.

Introductory Addictions Management Course — May 14-16, Toronto, Ontario. Information: Doreen Ross, Addiction Research Foundation (ARF), School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

North American Society of Adlerian Psychology and "NASAP 84" — May 25-29, Toronto, Ontario. Information: Katy Anderson, Publicity Director, Alfred Adler Institute of Ontario, 4 Finch Ave W, Ste 10, Willowdale, ON M2N 2G5

Canadian Psychological Association Conference — May 30-June 2, Ottawa, Ontario. Information: Dr Katherine Schultz, department of Psychology, University of Winnipeg, 515 Portage Ave, Winnipeg, Manitoba R3B 2E9.

Alcohol, Other Drugs and the Law Course — June 4-6, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Impact 84, The Citizen and the Criminal Justice System — An International Seminar — June 17-21, Toronto, Ontario. Information: R. E. Fox, Ste 214, 75 Lemonwood Dr, Islington, ON M9A 4L3.

Canada Safety Council 16th Annual Safety Conference — June 24-27, Ottawa, Ontario. Information: Canada Safety Council, 1765 St Laurent Blvd, Ottawa, ON K1G 3V4.

9th International Congress of Dietetics — July 2-6, Toronto, Ontario. Information: Congress Canada, Ste 603, 250 University Ave, Toronto, ON M5H 3E5.

26th Annual Scientific Assembly of The College of Family Physicians of Canada — July 8-11, Vancouver, British Columbia. Information: The College of Family Physicians of Canada, 400 Leslie St, Willowdale, ON M2K 2R9.

25th Annual Institute on Addiction Studies — July 15-20, Hamilton, Ontario. Information: Karl N. Burden, Course Director, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

Summer Fundamental Concepts Course — July 16-19, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Medical Women's International Association 60th Congress: Men and Women, Biological and Behavioral Differences — July 29-Aug 4, Vancouver, British Columbia. Information: Congress Secretariat, Medical Women's International Association, #1704-1200 Alberni St, Vancouver, BC V6E 1A6.

Canadian Society of Forensic Science 31st Annual Conference —Aug 18-24, Winnipeg, Manitoba. Information: Executive Secretary, Canadian Society of Forensic Science, 171 Nepean St, Ste 303, Ottawa, Ontario K2P 0B4.

1984 Annual Convention of the American Psychological Association — Aug 24-28, Toronto, Ontario. Information: American Psychological Association, 1200 17th St, NW, Washington, DC 20036.

University of Toronto Department of Psychiatry 10th Annual Research Day — Sept 14, Toronto, Ontario. Information: K. Drysdale, Secretary, Research Fund Committee, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Workplace 84 — "Making the Most of Human Potential", An Employee Assistance Programming Conference — Oct 15-17, Grande Prairie, Alberta. Information: Iyas Abbas, Alberta Alcoholism and Drug Abuse Commission, Provincial Bldg, Rm 2204, 10320 99th St, Grande Prairie, AB T8V 6J4.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-9, 1985, Calgary, Alberta. Information: Jan Skirrow, Chairman, 34th ICAA Congress, AADAC, 6th floor, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

United States

Annual Conference of the Association of Halfway Houses Alcoholism Programs of North America — May 20-23, Santa Monica, California. Information: AHHAP, 7786 E 7th St, Minneapolis, Minnesota, 55106.

National Conference on Women and Alcoholism — May 23-25, Seattle, Washington. Information: Dr Geri Marr Burdman, department of Community Health Care Systems SM-24, University of Washington, Seattle, WA 98195.

3rd Annual National Conference on Alcoholism and the Family — May 23-27, Philadelphia, Pennsylvania. Information: Mike Woodnick, The Caron Foundation, Box 277, Wernersville, PA 19565.

46th Annual Scientific Meeting of the Committee on Problems of Drug Dependence — June 4-6, St Louis, Missouri. Information: Dr Joseph Cochin, department of Pharmacology, Boston University, School of Medicine, 80 E Concord St, Boston, Massachusetts 02118.

5th Annual National Conference on Employee Assistance Programming — June 4-7, Kansas City, Kansas. Information: Bethany Medical Center, The EAP Conference, 51 N 12th St, Kansas City, KS 66102.

Central States Institute of Addiction, Continuing Education Program on Addiction, 3rd Annual June Institute — June 11-15, Chicago, Illinois. Information: Stella Nicholson, or Mary Wannop-Catelain, Central States Institute of Addiction, 120 W Huron St, Chicago, IL 60610.

National Association of Alcoholism and Drug Abuse Counsellor's Annual Conference — Aug 4-8, Indianapolis, Indiana. Information: NAADAC, 951 S George Mason Dr, Arlington, Virginia 22204.

The International Doctors in Alcoholics Anonymous Annual Meeting — Aug 9-12, Minneapolis, Minnesota. Information: Lewis Reed, MD, Information Secretary, IDAA, 1950 Volney Rd, Youngstown, Ohio 44511.

2nd Annual Institute on the Management of Substance Abuse Services — Aug 14-16, Cambridge, Massachusetts. Information: Barry Sugarman, Professor of Management, Lesley College Graduate School, 29 Everett St, Cambridge, MA 02238

Alcohol and Drug Problems Association (ADPA) 35th Annual Conference — Aug 19-23, Washington, DC. Information: Eric Scharf, Alcohol and Drug Problems Association, 1101 15th St, NW, #204, Washington, DC 20005.

Alcohol and Drug Problems Association (ADPA) Northwestern Regional Conference — Oct 7-9, Seattle, Washington. Information: Eric Scharf, Alcohol and Drug Problems Association, 1101 15th St, NW, #204, Washington, DC 20005.

18th Annual Association for the Advancement of Behavior Therapy Convention — Nov 1-4, Philadelphia, Pennsylvania. Information: John E. Martin, Program Chairperson, AABT/84, Psychology (116B), VA Medical Center, Jackson, Mississippi 39216.

4th Annual Fall Conference on Alcoholism — Nov 7-9, Williamsburg, Virginia. Information: Craig Nuckles, director, Riverside Hospital Alcoholism Treatment Program, J. Clyde Morris Blvd, Newport News, VA.

2nd National Conference on Alcohol and Drug Abuse Programming for Colleges and Universities — Nov 11-14, Boston, Massachusetts. Information: Eric Scharf, Alcohol and Drug Problems Association, 1101 15th St, NW, #204, Washington, DC 20005.

Abroad

30th International Institute on the Prevention and Treatment of Alcoholism and 14th International Institute on the Prevention and Treatment of Drug Dependency — Athens, Greece, May 27-June 2. Information: International Council on Alcohol and Addictions (ICAA), Case postale 140, 1001 Lausanne, Switzerland.

3rd European Acupuncture and Alternative Medicine Symposium — June 1-3, Stockholm, Sweden. Information: Secretary General, Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

15th World Congress of Rehabilitation International — June 4-8, Lisbon, Portugal. Information: National Secretariat for Rehabilitation, International Fair of Lisbon, Praca das Industrias, 1399 Lisbon-Codex.

III Congreso Iberoamericano sobre Alcoholismo — June 19-22, Cuenca, Ecuador. Information: Centre de Rehabilitacion de Alcoholicos, Casilla 331, Ecuador.

Families with Alcohol Problems: Models of Intervention — June 26-29, Dublin, Ireland. Information: Monica McGoldrick, Family Training Program, UMDNJ-RMS-CMHC, Piscataway, New Jersey 08854.

3rd Biennial American University School of Justice Institute on Juvenile Justice —July 8-July 27, London, England. Information: Professor Richard A. Myren, Director, Institute on Juvenile Justice in England and America, School of Justice, The American University, Washington, DC 20016.

International Narcotic Research Conference — July 22-27, Cambridge, England. Information: Linda Byford, Parke Davis Research Unit, Addenbrookes Hospital Site, Cambridge CB2, 2QB UK.

3rd International Conference on Treatment of Addictive Behaviors — Aug 12-16, North Berwick (Edinburgh), Scotland. Information: Dr William R. Miller, department of Psychology, University of New Mexico, Albuquerque, New Mexico 87131.

5th World Congress on Prevention — Aug 26-30, Rio de Janeiro, Brazil. Information: Ernest H. J. Steed, Executive Director, International Commission for the Prevention of Alcoholism and Drug Dependency, 6830 Laurel St, NW, Washington DC 20012.

8th World Conference of Therapeutic Communities — NEW REVISED DATES — Sept 2-7, Rome, Italy. Information: Charles J. Devlin, Executive Director, Daytop Village Inc, 54 W 40th St, New York, NY 10018.

Seminar on Addiction — Sept 6-14, Athens, Greece. Information: Darcy Edwards, Millglen Medical Corp, PO Box 888673, Atlanta, Georgia 30356-0673.

International Congress on Alcohol Dependence, the Family and the Community — Sept 16-22, Jerusalem, Israel. Information: International Congress on Alcohol Dependence, the Family and the Community, Kenness International Inc, 1 Park Ave, New York, NY 10017.

11th International Conference of Social Gerontology — Oct 16-19, Rome, Italy. Information: International Center of Social Gerontology, 91, rue Jouffroy, 75017 Paris, France.

1984 World Congress of Acupuncture and Natural Medicines — Oct 19-24, Colombo, Sri Lanka. Information: Dr Anton Jayasuriya, Secretary-General, Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

2nd Inter-American Symposium on Health Education — Nov 4-9, Acapulco, Mexico. Information: Symposium Steering Committee, c/o NARO, PO Box 2305, Station "D," Ottawa, Ontario, K1P 5K0.

Prophylactics of Drug Abuse — Dec 10-12, Warsaw, Poland. Information: Secretariat of the Symposium, Society for Prevention of Drug Abuse, Aleje Ujazdowskie 22, 00-478 Warsaw, Poland.

12th International Conference on Health Education — Sept 1-6, 1985, Dublin, Ireland. Information: Dr H. D. Crawley, Director, Health Education Bureau, 34 Upper Mount St, Dublin, Ireland.

Victims and offenders often using alcohol or drugs

Coroner probes prison violence, drugs link

By Anne Kershaw

KINGSTON — A coroner's investigation has linked the high number of murders and violent assaults inside several federal prisons in Ontario to widespread drug and alcohol use by inmates.

Robert MacMillan, MD, regional coroner for Eastern Ontario, launched a study into 11 prison homicides occurring since January 1982. His report, released last month, revealed seven of the first nine slain prisoners had evidence of alcohol, cannabis, or other drugs in their systems at the time of death.

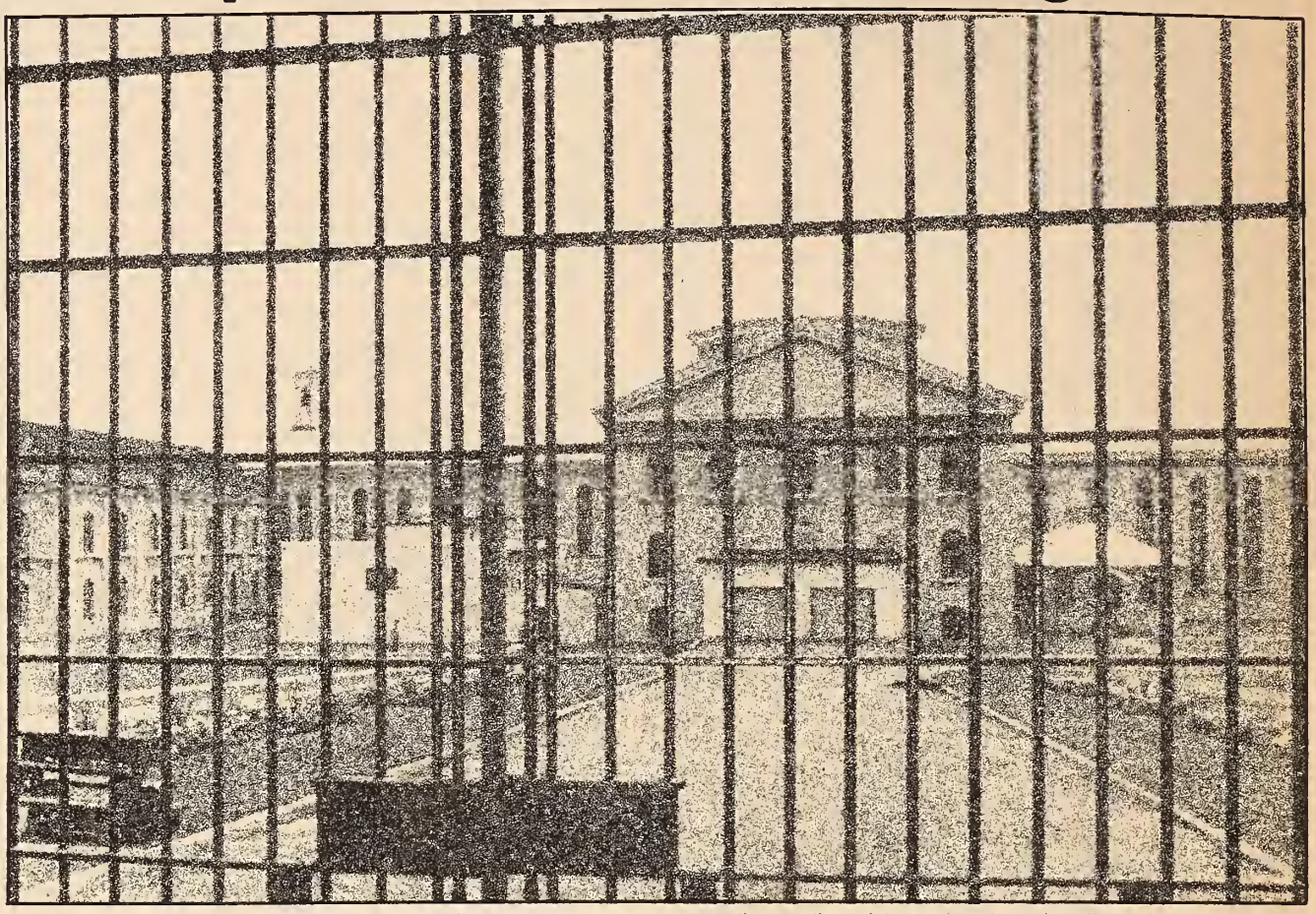
Dr MacMillan said it was impossible to know if the murderers were also intoxicated because arrests were, in some cases, made long after the killings.

But, he said, "in several cases, it is almost certain that the offenders have been, to some degree, under the influence of alcohol or drugs."

Toxicology results from the 10th and 11th victims were not available when Dr MacMillan wrote his report, and two more murders have been committed at Millhaven Institution here since he submitted his findings to the Chief Coroner for Ontario, Dr Ross Bennett.

For **The Journal**, *Dr MacMillan and other experts talk to reporter Anne Kershaw about the prison environment and drug use.*

* * *



Kingston Penitentiary: 'violence follows more from circumstances surrounding trading of drugs than from the effect of the drug itself'

The illicit drug trade within penal institutions is well known, says Dr MacMillan. And, "all evidence obtained indicates there is an increasing problem with illicit drugs that is becoming worse each year."

Chief intoxicants used by prisoners are home brew, Valium (diazepam), and marijuana and hashish.

Says Dr MacMillan: "The distillation of alcoholic beverages in the institutions is widespread. It appears that a wide variety of organic materials is used in order to produce these alcoholic beverages. Specific inmates become experts as brew masters and are able to distill alcohol from any foodstuff.

"In a number of the cases I reviewed, there is indication of alcohol both in the deceased and, strongly suspected, in the perpetrators."

Valium most common

Dr MacMillan reported that Valium is commonly available in the prisons. Although it tends not to be prescribed inside prisons because of its known illicit value, the drug is brought in by inmates returning from passes.

"Although searches are made, it is difficult to perform body searches, in particular body cavity searches, on every inmate who returns to the institutions," Dr MacMillan notes.

Furthermore, cavity searches are rarely carried out, partly because prison physicians and nurses "are loathe" to become tools of the administration by becoming involved in prison security.

Dr MacMillan also found traces of marijuana or hashish in one-half of the murdered inmates, and he speculates that most of the drugs entered the maximum-security Millhaven Institution through food prepared at its minimum-security annex, Bath Institute. Prison visitors are another suspected source of drugs.

"With Valium, I'm convinced it removes some inhibitions and a person gets more aggressive, hostile, and fearless," Dr MacMillan said. He referred to a 1975 study carried out by Dr Ron Workman, a Millhaven physician, which showed Valium in a prison setting often will increase violence, assaults, and hostilities.

MacMillan: (above) drugs may enter Millhaven Institution in food

There are six major prisons in the Ontario region where the rash of prison murders and assaults has occurred. All but one, Warkworth Institution near Peterborough, are located in or near Kingston.

Dr MacMillan launched his investigation into prison violence in December 1983, because of mounting public concern.

There were five murders in Kingston and area prisons in the first three months of this year, compared to a total of four for all of 1983. They included the January slaying of a 30-year-old Frontenac Institution inmate, the first prisoner in Canada to be murdered at a minimum-security prison, and the February murder of an 18-year-old at medium-security Collins Bay Institution. The latest murder — the third at the maximum-security Millhaven Institution located 17 miles outside of Kingston — occurred March 23.

Dr MacMillan said that while he focused on murders, he is equally concerned about "an apparent increase" in violent inmate assaults. "In many of these assaults, the outcome very well might have been fatal, as numerous weapons, including knives and bars, were used."

Canada's Solicitor General Robert Kaplan launched his own internal investigation in February. A four-member team is expected to present its findings this month.

Meanwhile, Dr MacMillan recommends more scrutiny and searching of outside visitors, better searches of inmates following visits, more regular searches of inmate cells, more closed visits, and fewer multiple visits. And he says prison authorities should have stricter rules to govern visits, including "plexiglass screens," in some cases, to separate inmates and their visitors.

Dr MacMillan also cited easy access to lethal weapons inside prisons as a reason for increased violence.

Others who work with prisoners, however, say it's simplistic to blame prison violence on drug use and the availability of weapons.

"Prison violence existed long before drugs came on the scene," says Graham Stewart, executive director of Kingston's John Howard Society (a private agency working with prisoners and parolees). "You can't look at the factor of drugs without looking at the broader situation in which prisoners are currently living.

"You're talking about a prison environment that is highly overcrowded and where there is limited activity. To suggest drug use is the cause of violence overlooks the reality that people take drugs for a reason, and that drugs have a value to people for specific reasons. It's like saying people are killed because they've been struck by bullets.

"Sure bullets kill people, but that gives you no understanding of the person's death."

Violence follows

William Miles, PhD, chief of psychological services at Kingston Penitentiary's treatment centre, told **The Journal** that prison violence follows more from the circumstances surrounding the trading of drugs than from the intoxicating effect of the drug itself.

"It's the payments, the jealousies, the debts incurred, the lack of fulfilled commitments," he said. "If you incur a debt (in prison), it has to be paid for one way or another."

Dr Miles said most prison physicians now steer away from preparations like Valium and other benzodiazepines which can be stored and then traded or sold. Prison physicians prefer drugs that can be given in liquid form, he said.

A tranquillizer favored by prison doctors is the anti-psychotic chlorpromazine (Largactil) because it tends to "smooth out behavior without producing a high." Dr Miles points out, as well, that two drugs known to cause violent behavior — amphetamines and PCP (phencyclidine) — haven't been found in prisons.

"These are drugs that are often used by criminal elements but aren't easily available because they aren't thought to have any therapeutic use," he says. "The drugs being used in prison are those in circulation in society at large."

Barbiturates rare

Dr Miles said he has heard only rarely of barbiturates being used by prisoners. Because the drugs are not often prescribed, they seldom find their way inside prison.

Other drugs such as heroin and cocaine are too expensive for prisoners, Dr Miles said.

But he doesn't believe there is any simple explanation for the recent surge of prison violence.

"It's (violence) far too complex to be linked to one variable such as drugs. The reasons for increasing violence today are different from the reasons for increasing violence tomorrow," he says.

In his report, Dr MacMillan recommends the introduction of urine screening tests on inmates suspected of being under the influence of drugs or alcohol.

Dr Miles agrees with the recommendation. He said urine tests would be useful not only as a way of monitoring people, but as a means of finding out what kinds of drugs are getting into prisons. But he said such tests, when used without consent and for a non-medical purpose, pose difficult ethical questions.

Dr Miles said a prisoner would have to be informed if a blood or urine sample were being taken for the purpose of detecting drug use.

Otherwise, Dr Miles said, "sticking a needle in someone's arm could constitute an assault."

THE BACK PAGE

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The Journal

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Broad policy planning a must for agencies

Draper slams ad hoc approach to alcohol

By Anne MacLennan

HALIFAX — Addiction agencies across Canada should stop blaming people for being deviant because they drink, and start working with the public to shape a clear policy on how to deal with alcohol.

For the moment, policy is "incremental ad hocery," says Ron G. Draper, director-general of the Health Promotion Directorate, National Health and Welfare.

Messages are delivered in "ad hoc, short-term campaigns, most of which are badly designed," he told **The Journal**. Particularly among adolescent and young adults, he said, they are "creating nothing except cognitive dissonance.

"We say to them drink and don't drive, and yet we put a road house with a parking lot on every corner. And we allow universities to have beer halls that are open for very long periods of time right in the common rooms, right on campus.

"What we're doing from the public policy point of view is giving inconsistent messages — the very opposite of the public health model. The message they're getting from the regulatory side is much more real, much more impressive."

Mr Draper said development of a comprehensive policy is "quintessentially a political problem," and leadership will ultimately have to be provided by the provincial commissions and by provincial ministries of health which, in turn, will have to have agreement from their cabinets because the "issues are interministerial."

But, he said, "given the balance of power in the field, there's going to have to be some interactive process that goes on between government bodies and the public before any significant action is going to take place."

He said policy initiatives have been checked by the interaction of such factors as politics, the conflicting aims of health-related agencies and the alcohol industry, the "normalization" of alcohol use by society, and even "bureaucratic inertia.

"No matter where you go in the internal part of the system, whoever you talk to, people all feel themselves very much inhibited by these constraints.

"I think the very fact that addiction agencies in the 1980s do not have the political support they had in the 1970s makes that probably a realistic appraisal of where they're at.

"So, I think that means the only place you can start is with activities that initiate public discussion and public debate."

Mr Draper was commenting in a telephone interview on a report — *Alcohol in Canada: A National Perspective** — released here in May at the Atlantic region meeting of the Canadian Addictions Foundation.

The report was prepared by an independent working group drawn from two provincial alcohol commissions, two federal government departments, and four Canadian universities.

It's the latest in a series of essentially statistical reports begun under the aegis of the Federal-Provincial Subcommittee on Alcohol and Other Drug Problems and National Health and Welfare. But it is the first to tackle — for wide consumption — the question of a comprehensive alcohol policy.

Draper: inconsistent messages

Setting the stage for its policy discussion, the report notes Canada's support of a May, 1983, World Health Organization resolution calling on all member nations to formulate comprehensive national policies on alcohol.

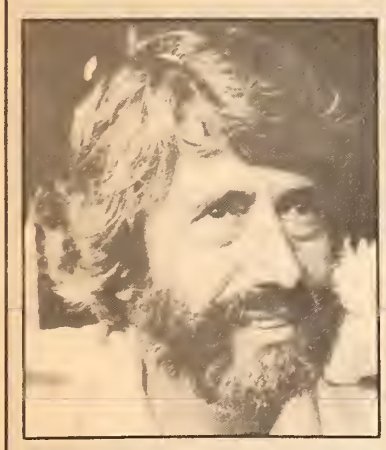
Adds the report: "This recommendation is very pertinent to development of effective responses . . . in Canada. To address this resolution realistically, the issues and context of alcohol policy development in Canada must be seriously considered."

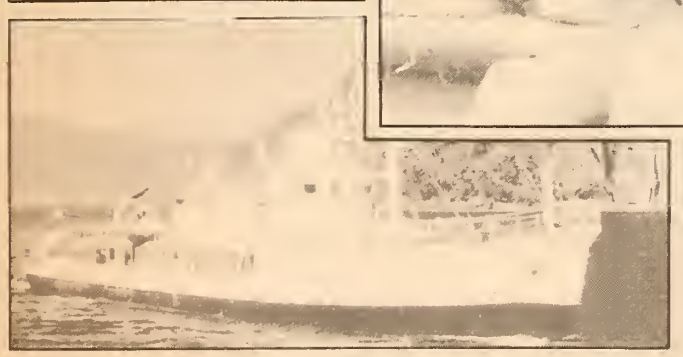
While the report makes no recommendations as such, it does say policies on alcohol have been reactive rather than proactive, describes a series of "substantial impediments to alcohol policy," and says these cannot be overcome "unless policy development becomes a key focus of alcohol agencies in Canada."

As for the current situation, it "is

(See — Alcohol policy — page 2)

Cousteaus probe the heart of coca country





A child in Iquitos, Peru, looks out on a world devastated by coca leaf, say environmentalists Jean-Michel (top left) and his father, Jacques Cousteau, who sailed the Amazon aboard the Calypso (left). **Harvey McConnell** *reports, page 9.*

RCMP on alert for cocaine-processing labs

By Anne MacLennan

TORONTO — There is growing concern that international drug traffickers are considering importing coca paste — the cheap first product of the extraction from the coca bush leaf — into Canada, says a senior federal narcotics officer.

The fear is the paste will be brought in and "clandestine cocaine-processing laboratories" set up to refine the drug into cocaine hydrochloride — the popular white powder, Inspector Don F. Willett of the Royal Canadian Mounted Police (RCMP) has told **The Journal**.

The concern follows reports that United States drug enforcement officials are now uncovering increasing numbers of illicit cocaine-processing laboratories there.

Although US labs appear essentially to be importing coca base — a later-stage product of extraction — and transforming it into the popular powder, enforcement officials here fear paste traffickers may be eyeing Canada.

"We've had some indication this may be so," said Inspector Willett, assistant officer in charge, RCMP drug enforcement branch headquarters in Ottawa.

The gluey, brownish paste is the focus of recent reports (**The Journal**, May) from Bolivian cocaine expert Nils Noya, director of rehabilitation and prevention services in Santa Cruz, the heart of Bolivia's cocaine-producing area.

He warned that the smoking of coca paste "cigarettes" is spreading dramatically in some South American countries and that addiction to the paste is more immediate, more reinforcing, and less treatable than cocaine addiction.

He said large-scale importation and abuse of paste in North America would produce "devastating results."

If traffickers can get a cheaper drug to sell here in North America, he said, "they can hook a lot more people, which is good business. Why shouldn't they do it?"

The cost of the paste would be one advantage to traffickers. Price

(See — Paste — page 2)

INSIDE

NEWS

CAF chief sets sights on grass roots

By Anne MacLennan

HALIFAX — The new president of the Canadian Addictions Foundation (CAF), a 30-year union man, wants to make the group a "powerful, national lobby for the field in Canada."

Ken Fraser is a special projects officer to the executive management committee of the Public Service Alliance of Canada (PSAC) and, "I believe, the first national CAF president who doesn't earn his living in the field of addictions.

"And that bodes well. I bring a little different perspective," he told **The Journal** at the Atlantic region meeting here of the organization.

Union work was Mr Fraser's entrée to the addictions field.

A developer for the Canadian Labor Congress (CLC) of its landmark employee recovery program, and for two years national coordinator of the program on secondment from PSAC, Mr Fraser is currently working to develop "meaningful employee assistance programs" in the 350,000-strong federal public service.

As CAF president, he sees as a chief objective expansion of grass roots support across the country and establishment of local chapters of the organization.

"For too long, the CAF has been known as an old boys' club and suffered, wrongly, from the appearance of being controlled by the provincial addictions foundations. But that is no longer true.

"It has made a tremendous effort to become what it is supposed to be — the national voice of the addictions community. I think there are now a lot of concerned citizens.

"And, as I've espoused many times, we must get grass roots participation. You can't lobby effectively without it."

Establishment of local chapters was approved by the board at its meeting here.

"We've set a goal for this year of five chapters — the first one is in Grand Cache, Alberta. And I'd say that within months we'll have five in Nova Scotia alone.

"We've set a five-year target of 50 chapters. But I'll be surprised if we don't reach 50 chapters years ahead of the five-year period."

A project of immediate importance, he said, is further development of a special interest group on employee assistance programs.

"The support we've got and the encouragement from business and labor people, and practitioners and workers, is, I think, a major growth factor in terms of our image and membership," he said.

Another target is coordination of a National Drug Awareness Week for 1985 to attract "more public awareness and support for CAF."

Although the four Atlantic provinces — Nova Scotia, New Brunswick, Prince Edward Island, and Newfoundland and Labrador — now work jointly on a drug awareness week, the new president and board want to see this expanded, with cooperation among other provincial and territorial agencies, across Canada. In principle, most provinces have agreed already to the project, he said.

The board also approved at its meeting a formal link with the newly formed Canadian Association for Addiction Nurses — a cooperative effort that could signal the beginning of "further ties with such groups as doctors and lawyers," said Mr Fraser.

The nurses' group, says president Diane Jonckheere, a nurse at Royal Ottawa Hospital, is for nurses who specialize in treating addictions but will also "look at the question of addiction among nurses," and act as a referral group.

Fraser: a national voice

Formed formally in April, the association is looking for about 500 members by the end of the year, says Ms Jonckheere. Meanwhile, the group plans to develop a national data base of addiction nurses.

Mr Fraser succeeds as CAF president, E.T. (Ed) Fitzpatrick, coordinator of employee assistance programs, Nova Scotia Commission on Drug Dependency.

Regulatory controls could curb alcohol troubles

By Anne MacLennan

DETROIT — Once alcohol is available in a commercial way in a community, the major prevention effort has got to be on the regulatory side, says Dan E. Beauchamp, president-elect of the National Association for Public Health Policy in the United States.

And, while the alcohol industry may go too far in thinking "society is going to rise up and lay them low," health workers ought not "to be so shocked to find that the aggressive pursuit of profit produces excesses that are very harmful to the public health."

Health workers must have a "healthy sense of the inherent conflict between themselves and the industry," Dr Beauchamp told **The Journal** here at the National Forum on Alcoholism.

"I don't think you can do anything about alcohol and health, or about smoking and health, or, in the US, about hospital costs, without somehow or other adversely affecting the financial interest of an important industry or profession.

"In the US, for example," he said, "to do something about hospital costs, you've got to do something about the fact industry and physicians have a very strong interest and a larger and larger piece of the pie all the time. The major enemy of controlling costs is the medical lobby and the hospital lobby."

Health care and social costs related to alcohol and tobacco use are similar, he said. And if the costs of use to society are to be curbed in more than a piecemeal way, controls have to be applied to the industries.

"I think the clash between industries and the community is inevitable in any complicated society. And it's the same between the individual and the community," Dr Beauchamp said.

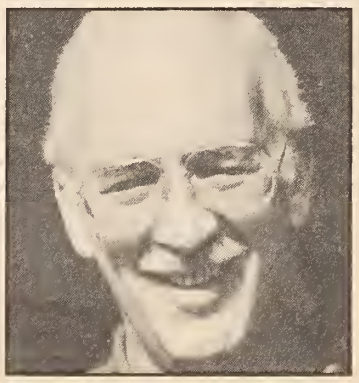
"Public health problems are rooted in what people in their everyday lives are doing in their own best interests, but it turns out to make everybody worse off.

"Nobody wants restrictions on their private privileges; they figure it's purely a matter of personal choice. And industry looks at it in the same way."

He said it is the role of governments to "take the big picture. And, practically speaking, you have to go for those changes that affect huge numbers of people as unobtrusively as possible."

He said while many people believe there are "a hundred things to be done, I think there are about six or seven. Once they're done, they'll need to be touched up, but basically, we'll be able to get on to new things."

A first important step would be to increase and adjust taxation policies. "Taxation is not a cumbersome, bureaucratic mechanism; it's there, and we can do it in a way that is minimally painful, and we can explain as we go along."



Beauchamp: clashes inevitable

Control on the age limit for drinking should also be uniform and higher than 18. "I support 21; others think 20. I think uniform and higher than 18."

There should also be controls on advertising of alcohol, adverse health effects should be noted on labels, and labels should list contents of beverages "to get people to see alcohol as a commodity in commerce like anything else and to get it out of favored treatment category.

"Another thing, and it's difficult, I would like to see revitalized state and local licensing and sales of alcohol.

"It should be easier for citizens and public health people to impact the process by which alcohol is sold or consumed in retail establishments. I mean, more citizen participation in the process by which liquor licences are obtained and renewed, more control over the number and location of retail outlets, and, at the federal level, more control of advertising by the alcohol industry."

Dr Beauchamp, also professor, department of health policy and administration, School of Public Health, University of North Carolina, Chapel Hill, and chair, Council on Alcohol Policy, Berkeley, Cal, added: "The majority of people aren't very much involved with alcohol.

"Most people don't drink, or they drink minimally. Alcohol policy, on the other hand, basically as a result of neglect, serves the interests of the industry and their principal targets, the small number of people who do drink frequently and heavily.

"You can't have public health or an integrated alcohol policy without the understanding that the majority of the population agrees that alcohol should be a limited part of everyone's life. If we don't have that, we're not going to get anywhere."

Alcohol policy issues 'pretty basic'

(from page 1)

likely to involve greater advantages for the sectors involved in the production, distribution, and sale of alcohol and (for) the minority of the population who drink frequently and in large quantities."

The "critical policy questions" the document raises are "really pretty basic," says one of the authors of the report, Norman Giesbrecht, PhD, a scientist at Ontario's Addiction Research Foundation (ARF) in Toronto.

Dr Giesbrecht told **The Journal** the essential questions are: "First of all, do we want an alcohol policy? Whether it's a liberal policy, an ad hoc policy, or a forward-looking public health policy — do we want a policy?

"Next, do we want a policy on just one part of the pie? A policy on drinking and driving, for example, seems to be evolving. Or, can we have a policy that encompasses the whole pie? From that, certain things arise for particular target groups.

"Third, and probably central, is: What is the status of alcohol? If the status is the same as that of milk, or Coca-Cola, then a whole series of policies follow from that. If the status is that of a drug — and it is a drug — then a whole series of policies follow," Dr Giesbrecht said.

If a policy is developed the report suggests, and between the lines recommends, one perspective is the "public health perspective."

Giesbrecht: wide appeal

This "can appeal to a wide variety of divergent and perhaps conflicting interests," says the report. It then goes on to explain that a public health perspective consists of three elements — the host, representing the individual who may be at risk of problems; the agent, that is the alcohol itself; and the environment — physical and social factors external to the individual.

"All these factors must be considered in any comprehensive attempt to deal with alcohol-related problems," it says. (See — Public Debate and Community Initiatives — The Back Page)

Comments Mr Draper: "Probably the best page in that entire report is the page that discusses what it means to approach this from a public health perspective. Every word is important. That's the first point.

"The second point is to recognize that alcohol programing now being done is not being done from the public health perspective. And the research now being done is not being done from the public health perspective. It's all individualized, blame-the-victim, focus on the clinical issues."

He added: "The field is dominated by biomedical models right back to its beginnings. This is not to dismiss those models as irrelevant. But the exclusive focus on them, or virtually exclusive focus, is destructive."

Mr Draper said agencies should have "what I call an open information policy . . . discussing with the public what they, the public, want in future and bringing into that discussion informed insights into what's going on now (with policy) and what the implications might be.

"If they can't do that, then they can't do anything.

"For example, the public needs to know that amongst them the brewing companies virtually dominate the professional sports area and that they're moving now into rock music."

Dr Irving Rootman, chief, Health Promotion Studies, Health Promotion Directorate, Health and Welfare, Ottawa, was coordinator.

** Published by the authority of the Minister of National Health and Welfare and to be distributed through the provincial commissions on alcohol and drugs.*

Paste is cheap but bulky

(from page 1)

per kilogram at source ranges from $4,500 to $7,000 per kg, and cocaine hydrochloride from $7,500 to $18,000 per kg.

Paste is also still relatively easy to smuggle, says Inspector Willett.

Although it has a strong and distinct odor, that odor is not yet generally recognized beyond South America. And, dogs that are used to sniff out suspect cargoes for drugs such as marijuana and cocaine have not yet been trained on any scale to identify the distinct smell of the paste.

A more immediate disadvantage of the paste for traffickers is its bulk. It takes 2.5 kg of paste to produce 1 kg of cocaine base which, in turn, can be transformed into cocaine on a one-to-one ratio.

However, as Dr Noya has pointed out, paste could attract a new market of users less affluent than cocaine users. And as one observer has noted, "marijuana's bulk has not kept it out."

NEWS

Quick test for methyl alcohol will aid poisoning victims

By Terri Etherington

TORONTO — Doctors in emergency rooms and health care workers in Third World countries may have a faster, more efficient means of testing for methyl alcohol poisoning following the development of a new "dipstick" test at the Addiction Research Foundation (ARF) here.

Methyl alcohol, or wood alcohol (methanol), is found in windshield-washer antifreeze, paint removers, cleaning solvents, liquid fuels (Sterno), and some products of illicit stills. It may be consumed deliberately in suicide attempts, by "skid row" type alcoholics, or accidentally in the home, and may also be found in home-distilled liquor.

These compounds, when ingested in large amounts are often fatally toxic and, at the very least, can cause permanent blindness.

Early detection is critical in the successful treatment of patients, says Bhushan Kapur, PhD, who with Yedy Israel, PhD, developed the new test.

In the first four months of this year, three cases of methanol poisoning in the Toronto area were referred to the ARF's clinical institute, where Dr Kapur is director of clinical laboratories and Dr Israel

Israel

Kapur

heads the biochemical research department. Although the reported incidence of methanol poisoning in North America may be slight, Dr Kapur believes many cases go unreported.

And, in developing countries where illicitly distilled beverages are common, methanol poisoning is "very, very prevalent," says Dr Israel.

The new dipstick is similar to the ethanol-specific device developed here last year (**The Journal**, Aug 1983).

"When combined with the previously developed dipstick, which specifically reacts with ethanol, it will allow doctors to detect who is intoxicated with methanol, who is simultaneously intoxicated with ethanol and methanol, and the relative concentrations of both," Dr Israel told **The Journal**.

The original stick, with an alcohol dehydrogenase (ADH) based reagent pad, will likely be used in emergency units, in treatment centres to measure patient compliance, in industry for monitoring employee alcohol use, in physicians' offices, and, potentially, by the general public.

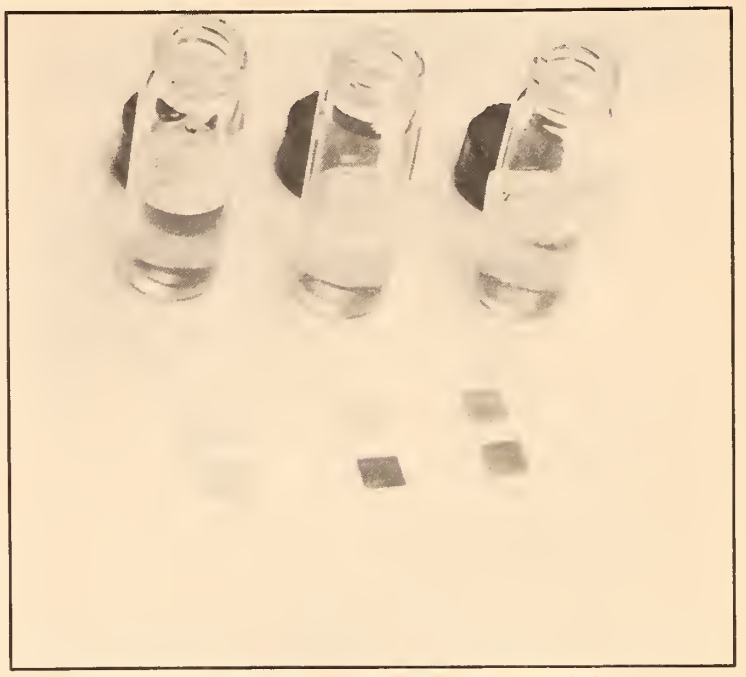
The second combines the ADH reagent pad with another based on alcohol oxidase (AO), sensitive to methanol, ethanol, and ethylene glycol (found in radiator antifreeze).

This two-pad dipstick would help hospital emergency rooms and trauma centres to detect methanol poisoning which, surprisingly, is treated by giving patients ethanol, by a shot of straight liquor, by intravenous infusion, or by dialysis.

Dr Israel explains that initially methanol poisoning victims can appear intoxicated with ethanol. Consequently, unless tests are done to determine accurately the presence of methanol, treatment is unlikely to include more alcohol.

The combination of the two pads on one dipstick will allow emergency room doctors to see immediately if ethanol, or methanol alone, has been taken, or a combination of the two. The relative colors of the two pads can give physicians accurate readings of body concentrations, and treatment can start immediately.

At present, methanol analyses are done by gas chromatography. However, says Dr Kapur, many emergency centres do not have the necessary instrumentation, and samples are sent to outside laboratories which is both costly and time consuming.



Double-dip quick test: blank sample, methanol, ethanol (l-r)

Like the earlier ethanol-specific dipstick, the new device combines a small reagent pad on a cellulose strip. It contains the enzyme, alcohol oxidase; a competitive inhibitor to control the rate of reaction; and an agent that responds to the chemical conversion of methanol, ethanol, or ethylene glycol by changing color. The intensity of the color produced on the pad is directly proportional to the concentration of the drug in the fluid being tested.

The blue color produced one minute after immersion in saliva or serum is matched against a color-coded reference chart to determine concentrations of the substance in the body.

Testing of the original ADH dipstick has shown it is reliable in clinical settings where patients are also likely to be using other drugs. No interference was found in in-vitro studies when 40 different, commonly-abused drugs were tested in urine. In-vivo studies, however, showed that when three or more drugs were present in large concentrations in the urine, there was a small inhibitory effect on color development.

However, there were no false negatives or false positives produced by the presence of these other drugs or of their metabolic products, and the researchers concluded the slight negative bias of the dipstick reading in these cases should not hamper clinical action.

At least five major manufacturers, including multinationals, have so far expressed an interest in developing the dipsticks. Product marketing is expected within a year.

Lung cancer in women topping state records

By Jean McCann

DAYTONA BEACH, Fla — For the first time, lung cancer in women now exceeds breast cancer as the leading cause of cancer death in 12 of the United States. And other states are expected to catch up, Gerald Murphy, president of the American Cancer Society, told the annual science writers' seminar here.

Dr Murphy, who criticized the tobacco industry for its ads encouraging women to smoke, said "in 1963, before the US Surgeon General's report linking smoking and cancer, only 6,500 women in the country were known to have died from smoking-related lung cancer. This year, we're talking about 36,000."

The 12 states in which lung cancer is the leading cause of death for women are Alaska, California, Florida, Hawaii, Kentucky, Louisiana, Nevada, Oklahoma, Oregon, Texas, Washington, and West Virginia, he said.

The highest rates were in Florida, which has a large number of elderly females. In 1982, the last year figures were available, there were 2,130 lung deaths versus 1,964 deaths from breast cancer.

Florida also had higher rates of lung cancer deaths in women in 1980 and 1981, Dr Murphy said.

But, he said, the tide, in general, may be turning.

Overall cigarette consumption dropped by 32 billion cigarettes in the US in 1983, reflecting a 7% decline in the adult smoking rate. The drop was particularly marked in individuals aged 35 to 44 years. Smoking rates among young adults are also declining, he added. "It's no longer considered smart to smoke."

This will, he hopes, be reflected by declining rates of lung cancer and other smoking-related diseases in the future.

Dr Murphy said the tide may also be turning because the tobacco industry, which spends far more on advertising than the National Cancer Institute budget, "has lost its credibility." More and more adults are not buying the "health" pitch of the tobacco companies, with its "Marlboro man" outdoor image.

When dreams are a taxing question

By Wayne Howell

"Huge and mighty forms that do not live
Like living men, moved slowly through the mind
By day, and were a trouble to my dreams"
William Wordsworth

The huge and mighty forms that moved through my mind on the day of April 30, 1984, were my Income Tax Forms. No doubt they played a role in the troubled dream I had that night, as did the brouhaha of the last few months concerning Revenue Canada's draconian interpretation of the tax statutes and the tales of sadistic auditors unearthed by the travelling Task Force on Tax Reform. And then there was the brochure from The Institute for the Advancement of Human Behavior that I received in the mail that day and perused just before I dropped off to sleep . . .

In the dream I am sitting in a hard-backed chair across from the desk of a stern-faced National Revenue auditor. He is flipping through papers on his desk. I recognize my 1984 income tax return.

"Now Mr H.," he says.

"The name is Howell."

"I know that. But we like to use just the initial — a little Kafkaesque touch," he says, with a thin-lipped smile.

"I trust everything is in order," I say, glancing around nervously.

"For the most part, yes. However, we do have some questions about this little item here: the $1,150 deduction for a conference entitled 'The Healing Power of Laughter and Play'."

"Oh that. In my capacity as a columnist for **The Journal** I attend conferences from time to time. Have to keep up, you know."

He reaches into a drawer and pulls out a red brochure which I recognize as the brochure I received in the mail 18 months ago.

"We are interested, Mr H., in why you attended this conference," he says, leafing through the brochure. "Was it to hear Dr Goodman 'tickle us with a variety of magic tricks to bring his ideas to life?' Was it the songs and sing-alongs of Dr Alsop which 'provide the perspective to help us take ourselves less seriously and shed self-imposed restrictions on being silly and having fun?' Was it for the session on the 'ho-ho-holistic view' of healing? Or was it to see the performance by 'The Amazing Jonathan'? Frankly, Mr H., it appears to us that when you decided to make this conference a deductible item you were merely following the admonition in the brochure to, and I quote, 'write yourself a prescription for a healthy share of belly-laughs.' "

"That conference was accredited as part of Continuing Education Requirements for health care workers. Personally, I got a lot out of the lecture on 'Graveyard Humor as a Healing Strategy.' If you don't believe the conference was valuable then read the 'participant comments' right there in the brochure," I say, jabbing my finger down on the second page.

He reads: 'I've never laughed so much at a professional conference — Jeff Crow, MFCC.'

'The only suggestion I can think of is this: I want more conferences like this — Edith Schwartz, Social Worker.'

He frowns and makes an ominous tapping sound with his pen on the desk. It is obvious that I am not getting through to him. He just doesn't understand. I think of a quotation from the brochure: 'in a society that emphasizes the value of cognitive, analytical thought, we sometimes miss the overview and healing balance a new perspective can give.'

"I suppose," he says with a sigh, "that you attended the seminar on 'Lifestyle and Disease' in which a Dr Simonton explained how he helps his patients increase their playfulness by teaching them to juggle."

"Of course. I even followed the instructions in the brochure and brought three objects I could juggle."

"Yes, I see," he says, looking at my tax return. "Three Sunkist Oranges: $1.20. Well, I'll give you a break there, despite the fact that, in my estimation, oranges with seeds in them would have been perfectly adequate for the purpose. But what really concerns me is why you opted for the 'Laughter and Play Cruise' which is described as 'a cruise for seven days aboard the luxurious "Tropical" from Los Angeles to Puerto Vallarta, Mazatlan, and Cabo San Lucas' in July, for $1,150, when you could have caught the same act in Toronto in May for only $245, workbook, lunch, and refreshments all inclusive."

"Oh, is that what's bothering you? I merely wanted to optimize the experience. Shedding self-imposed restrictions on being silly and having fun comes easier on a cruise ship — haven't you ever seen Love Boat?"

He rolls his eyes heavenward and reaches for his pen. He is about to make a decision. And precisely at that moment — at that crucial moment — I wake up.

I am frustrated beyond measure. Did he allow the deduction or not? Since dreams are ephemeral and cannot be relived, I will never know. I have the impression, however, that he was one of those cognitive, analytical types, incapable of taking a 'ho-ho-holistic' view of the situation.

NEWS

RESEARCH UPDATE

Caffeine aids analgesic effects

Contrary to widespread medical belief, caffeine can help relieve pain when added to over-the-counter pain killers, suggests a review of 30 clinical studies conducted during the past 20 years and involving more than 10,000 patients. It assessed the value of caffeine when added to drugs like acetylsalicylic acid and acetaminophen and involved patients taking analgesics for postpartum uterine cramping, gynecologic pain, headache, and pain from oral surgery. When the researchers from the Rockland Research Institute, New York University, and Bristol Myers pharmaceutical company pooled relative potency estimates of the analgesics with caffeine, compared to those without, they found that an analgesic lacking caffeine needs a 40% larger dose to obtain the same degree of pain relief as that obtained from an analgesic *with* caffeine. They speculated that the benefit of caffeine may be tied to its "mood-enhancing" properties. For many patients this could be of considerable clinical importance. The review said, "it seems reasonable to conclude that the addition of caffeine, 65mg, to an analgesic tablet taken in a two-tablet dose results in a more effective analgesic."

Journal of the American Medical Association, April 6, 1984, v.251:1711-1718

Nicotine danger for hemodialysis patients

Patients having hemodialysis for kidney disease have markedly higher nicotine levels after smoking cigarettes than control subjects and, therefore, may be at greater risk of cardiovascular disease. A Rhode Island study compared serum nicotine levels in 10 patients with end-stage renal disease undergoing maintenance hemodialysis, before and after smoking one cigarette and following dialysis, with control patients with no kidney disease. Researchers from the Roger Williams General Hospital and Brown University, found the hemodialysis patients had consistently higher serum levels of nicotine before smoking, immediately after, and some hours later. They attributed this more than threefold difference to a defect in nicotine elimination probably caused by impaired renal function. A related pilot study of two patients undergoing continuous dialysis indicated hemodialysis itself is unrelated to these elevated nicotine levels. "Our study supports the view that tobacco smoking may pose increased cardiovascular risks to patients with end-stage renal disease undergoing maintenance dialysis because of increased nicotine levels," the study concluded, noting that the study group was small, and controls were not matched for age or sex.

American Journal of Medicine, February 1984, v.76:241-246

Saliva tests spot driver drug use

A group of Ottawa researchers believe saliva can be used to detect drugs in impaired drivers. Working with three Ottawa area police forces, the researchers collected 56 saliva samples from 445 drivers stopped for suspected impaired driving and asked to participate in the study. Samples of 1ml to 1.5ml were obtained and screened for cannabinoids, basic/neutral/acid drugs (including cocaine, caffeine, and nicotine), benzodiazepines, and volatiles (including alcohol). Alcohol was detected in all 56 samples, and other drugs in 10 samples. Six samples had cannabinoids present, diazepam was found in four cases, and cocaine was detected in one case. Only three of those drivers with cannabinoid-positive tests admitted taking the drug. The study noted that saliva positive for cannabinoids does not necessarily mean that the substance will be detected in the blood. However, the presence of cannabinoids in saliva is indicative of recent consumption of the drug. The study, from the Central Forensic Laboratory of the Royal Canadian Mounted Police and the University of Ottawa, concluded that saliva sampling is a potentially versatile, non-invasive technique for determining occurrence and frequency of drug use in impaired drivers.

Journal of Forensic Sciences, January 1984, v.29:185-189

Alcohol an inhibitor of chronic lung disease?

Alcohol consumption reduces the incidence of a form of chronic lung disease, say Philip Pratt, MD, and Robin Vollmer, MD, from the departments of pathology, Duke University, and Durham Veterans Administration Medical Centers, Durham, NC. They studied 204 lungs autopsied for centrilobular emphysema (CLE). Data on smoking habits and alcohol consumption were available for all patients autopsied. The study found a clear trend for a decreasing prevalence of CLE as alcohol consumption increased in both smoking and non-smoking subjects. The relationship was not affected by the age of the subjects. The researchers were only able to obtain general background information which did not specify the type, amount, or duration of alcohol consumption, but they said the retrospective nature of smoking and drinking histories would tend to reduce, rather than exaggerate, any differences. They speculated that alcohol might reduce the incidence of CLE by inhibiting inflammatory cells which liberate enzymes causing the disease. While the researchers could "scarcely recommend alcohol consumption as a general prophylactic mechanism," they said drugs might exist with inhibitory effects on inflammatory cells similar to those of alcohol, and that these could be discovered once their proposed mechanism for the relation between CLE and alcohol is confirmed.

Chest, March 1984, v.85:372-377

Pat Rich

Smoking in the workplace drains profits, productivity

By Jean McCann

SAN FRANCISCO — Smoking in the workplace has become a "bottom-line" issue.

In the first conference here of top executives of major corporations to discuss the subject, Robert N. Beck, executive vice president of the Bank of America, said smoking is hurting business, and elaborated:

- Medical and hospital costs related to smoking in the United States ran to $32 billion in 1983 and will rise to $46 billion in 1985.
- Smokers lose from 33% to 45% more workdays and have 14% to 17% more bed-disability days than non-smokers.
- Smokers have 150% more bronchitis and emphysema than non-smokers, 80% more peptic ulcers, and 50% more heart disease.
- Health care costs in general, of which smoking-related diseases make up a large part, are raising the costs of consumer products. For instance, he said, General Motors added $480 to the cost of each car as a counter to these costs.

Mr Beck said the loss is also affecting companies' ability to compete.

"Employers pay because health premiums and disability costs go up," he said. "The loss of productivity makes it difficult to compete in the international marketplace. Families move because they lose a vital member, and the government also pays as an employer and an insurer. We all pay."

He said as a result, companies have a right to ban smoking in the workplace, if non-smokers object, under a recently-passed city ordinance (in San Francisco).

"When accommodation between smokers and non-smokers is not possible, the preference of the non-smoker should prevail," he continued. "Of course smoking should be prohibited where there is essentially hazardous material, or where it may be offensive to customers. Also, public areas like elevators, coffee rooms, waiting rooms, and so forth should be considered non-smoking areas."

Mr Beck said his own company had not gone so far as to ban the hiring of smokers, "although many corporations do."

Meanwhile, he said companies should "offer low-cost, health education programs through the workplace," to help employees quit. Companies can supply both the facilities for after- or before-work use, and financial assistance.

Mervyn Silverman, director of the department of public health for San Francisco, said tobacco smoke acts synergistically to increase toxic hazards already found in the workplace environment.

"For example, carbon monoxide levels of the occupational environment may add to the already-high carbon monoxide levels found in the blood of smokers. Hydrogen cyanide is also as high as 1,600 parts per million in cigarette smoke, and a study has shown that workers in electroplating factories had significantly higher concentrations of cyanide if they were smokers than if they were non-smokers exposed to the same occupational environment," Dr Silverman said.

Smoking also acts synergistically to cause lung cancer in uranium and asbestos workers, he said.

In addition, non-smokers suffer from inhalation of tobacco smoke when others smoke in the same environment.

"Under common law and various statutes," Dr Silverman told the meeting, "employers must provide healthy and safe working conditions. This basic requirement certainly should apply to the presence of unhealthy tobacco smoke in the workplace, as it does to other toxic subsances."

Workplace: non-smokers should prevail

Boss cajoles employees with perks and pressure to give up cigarettes

By Jean McCann

SAN FRANCISCO — Blue smoke coming from the employees' lounge area made Warren McPherson see red.

But, instead of going in and yanking the cigarettes out of people's mouths, as he felt like doing, the president of the Radar Electric Company decided to use an "incentive plan" to get employees to quit.

What angered him, Mr McPherson told a meeting here for top management — Saving Business the Costs of Smoking — was the fact he had just returned to his office from the funeral of his mother, who died of smoking-related cancer.

Because of this anger, he said, he decided smoking at Radar Electric would be phased out.

First, "I told them that any employee who quits smoking at the end of 30 days will get a 25-cents-an-hour raise, or $42.50 a month.

"A week later, I also told them 'If you quit smoking, you can take a half-hour on company time five days a week, and go to the new Nautilus (health) Club nearby. The company will pick up the cost and give you a half hour off in the morning.' "

The idea, he explained, was to stop people complaining they would gain weight if they quit. They could now keep that weight off by exercise.

With such lures about 25 of the smokers quit. However, this did not include key management figures, so the boss then went on to the next phase.

"I called in the remaining 18 or 20 people and told them 'I have a real problem. You people run my company, but if you're not smart enough to quit smoking, you're not smart enough to run my company.

" 'From this day forward, if you don't quit smoking you'll never be advanced. I'll never hire a smoker again. No one will smoke in the confines of this company.' "

He set a 30-day deadline for quitting, and the employees did quit. Customers proved more difficult. When a visitor *did* light up on the premises, an employee would hand him or her a card asking them not to smoke. The visitors complied, he said.

Mr McPherson said it is now six years since this took place, "and if you come in to Radar Electric, you're not allowed to smoke. It's also the first question on our employment application, in red: 'Do you smoke?' "

He added the incentive and pressure combination paid off, except in two instances.

"We got down to where we had two closet smokers left," Mr McPherson recalled.

"One, we fired. The other died of lung cancer."

'Last time they quit smoking, I netted $125 on their ashtrays.'

NEWS AND COMMENT

Neurologists probe potential benefits

Alcohol may aid myoclonic dystonia

BOSTON — While most alcohol-related research focuses on the negative effects of drinking on health, neurologists are probing the potential benefits of alcohol in some movement disorders.

Since a finding several years ago that drinking small amounts of alcohol throughout the day greatly reduces involuntary shaking of head and hands in benign essential tremor, researchers have started testing alcohol as a palliative in other conditions involving incurable, uncontrollable movements.

At the annual meeting of the American Academy of Neurology here, Niall Quinn said people with inherited myoclonic dystonia (a rare condition characterized by both involuntary muscle jerks and uncontrollable twisting movements of the limbs) "respond dramatically to alcohol."

Dr Quinn, a neurologist at King's College Hospital in London, England, and colleagues tested regular daily drinking in six patients with inherited myoclonic dystonia.

All of them improved dramatically, he said. "Unfortunately, though, one of our patients has become an alcoholic," Dr Quinn said. "It would be nice if we could develop a drug that reproduces the good effects of alcohol without the bad effects."

The amount of alcohol needed to keep myoclonic and dystonic movements under control is "one very strong beer to kick off the day and topping it off with small quantities throughout the day."

Quinn: one beer

GILBERT

'It would be a pity to leave the exploitation of such a valuable resource to commercial interests . . .'

More about beverage marketing

By Richard Gilbert

Last June in **The Journal** I reported on the Third Annual Canadian Beverage Marketing Seminar, and noted that listening to beverage marketing specialists — experts on making consumption go up — was a good place to get ideas about how to make consumption go down. I urged researchers, preventionists, and policy makers to pay more attention to the beverage marketing business, and suggested that this year's seminar would be a good place to start.

Well, so much for the influence of your columnist. This year there were even fewer participants in the Annual Canadian Beverage Marketing Seminar from the alcohol and addictions field than in 1983. Nor was the meeting quite as stimulating, but this was not to be known in advance. The theme was New Horizons in Beverage Marketing.

What came over most strongly was the extent to which commercial interests lead in the matter of determining everyday fluid consumption patterns among the different sectors of the population.

The Addiction Research Foundation (ARF) was once a leader in this important enterprise with its Ontario Drinking Survey, for which a representative sample of 1,894 Ontario residents aged 15 years and older was interviewed about drinking habits of all kinds during the spring of 1969. For many years this study provided the best data on, for example, the frequency distribution of consumption of alcoholic beverages in the population — vital knowledge if the amount of excessive alcohol use is to be determined and put in a proper context.

For some years now the best data for this province have been provided by the Ontario Milk Marketing Board — a semi-private agency with an interest in substituting milk for one or more of the seven drinks of all kinds that the typical adult downs each day. The first presentation at the 1984 seminar described this annual survey of 5,000 Ontario residents, aged 12 years and older, conducted for the Milk Marketing Board by the Research Management Group (RMG).

Interesting tidbits

Some interesting tidbits were revealed. Males consume 52% of drinks of all kinds. Some 40% of drinks are consumed with meals. Seventy-two percent of drinks are consumed at home. The peak age for consumption away from home is 20 years, which may also be the peak age for alcohol use. Beer is the beverage most likely to be drunk two or more drinks at a time, and the beverage least likely to be drunk with another. Twenty-four to 29 year olds drink the most different kinds of drinks each day (an average of 3.7).

Such data, gathered and organized systematically, are essential to an understanding of what it takes to alter beverage preferences. The beverage marketing industry knows it, but professionals concerned with reducing consumption of pharmacologically active beverages — people who are also in the business of altering beverage preferences — seem less and less interested in these kinds of data.

The tidbits of survey results provided by Chris Commins for the RMG were but a teaser for a presentation by his colleague, Tim Wingrove, who described a new endeavor — the annual CUP Report, which is to be a "national, syndicated study of daily beverage intake among the Canadian population." The data for the report will be derived from "a seven-day diary record of beverage intake completed by a projectable national sample." The sample is to be known as the Canadian Usage Panel. It will consist each month of about 350 randomly-selected individuals who will complete a week-long diary, staggered as to start date and detailing the following:

- exactly what was consumed — in nine broad categories and 186 sub-categories of beverage;
- where and when consumption took place;
- number of drinks per occasion;
- other drinks consumed at the same time; and,
- demographic features of the consumer, including sex, age, region, community size, employment, household size and income, and language.

Data collection for the CUP Report will begin in September. The annual cost of the report to subscribers will range from $15,000 to $36,000, according to the frequency of output required and the degree of refinement of the data. This seems a lot, but it would cost at least 10 times as much for an organization such as the ARF to generate the portion of the data it would be interested in.

In my view, the CUP report has the potential of providing a wealth of useful information about the consumption of alcohol- and caffeine-containing beverages, and the contexts of their consumption. I recommend strongly that the ARF arrange to purchase the full survey, beginning in 1985, and assign a researcher to extract, analyze, and report on the parts of it that drug abuse professionals might be interested in. It would be a pity to leave the exploitation of such a valuable resource to commercial interests.

The next presentation concerned a different kind of survey, the Needham Lifestyle Study, an annual investigation of the practices of 4,000 United States residents providing "a solid window into the mid-American household." Cautley Tatham, president of the Canadian arm of Needham, Harper & Steers, claimed that the US trends apply broadly in Canada, that information about them can act as a "DEW line for surprises from the south," that from the point of view of beverage marketing "we live not in the country but on a continent," and that "no government can legislate against geography."

Mr Tatham cautioned beverage marketers not to skim the surface of conventional wisdom about lifestyle, but to look at the qualifiers, presumably with the guidance of a company such as his. He outlined four what he called "yesbuts" — trends we know "to the point of exhaustion" that are not what they seem on closer analysis.

Four yesbuts

Yesbut #1 concerned women. "Yes," he said, "a lot of women are working. But," he added, "this is hardly a new trend, and the stereotype of them swarming into executive positions is quite misplaced."

Yesbut #2 cautioned against seeing all adults as madly jogging to keep fit. There is certainly greater awareness of healthy lifestyles, but there is also an enormous variety of ways in which this is put into practice. As well, it is important to know that young people exercise to do something, whereas older people exercise to avoid something.

Yesbut #3 made the point that most singles living alone are not habitués of singles bars, but rather, elderly women scraping together a bare existence.

Yesbut #4 advised that the baby boom has been misplaced by a decade. The peak decade for births in North America was 1955-1965, not 1945-1955. Thus the biggest bulge is just now hitting peak spending power.

Mr Tatham's observations illustrate the kind of information the beverage marketing industry uses to boost sales or to prevent declines in consumption. Exactly the same information could be valuable to those interested in achieving the opposite effects.

Mr Tatham's generalization of US trends to Canada should be questioned, however. Fundamental differences have existed between the US and Canada in trends in overall consumption of coffee, tea, and soft drinks during the past two decades (**The Journal**, Nov 1983). (There are smaller overall differences in trends in consumption of alcoholic beverages.) Mr Tatham seems less aware than he should be of Yesbut #5 — that Canada and the US look the same on the surface, but differences in climate and history have reached even into beverage consumption habits.

After what is known at other conferences as the coffee break, but here was called the refreshment break — so as not to give offence to tea marketers — we heard on behalf of Hoffman-La Roche Ltd an account of how nutritional refreshment beverages are the vogue in Japan and parts of Europe, and a prediction that they are the wave of the future here, although it should be realized that Canada is already the world leader in terms of the proportion of the total soft drink market comprising fruit juices.

In Japan the vogue is for "sport drinks," chemical concoctions with sodium and potassium salts added to make them more like the body's fluids. The theory is that they replace what is lost in sweat. In practice, the added salts are little more than a marketing gimmick, but apparently a very successful one — the market for this kind of product increased from $200 million to $300 million between 1982 and 1983.

Next the president of Canagrex, the federal government's marketing agency for agricultural exports, painted a rosy future for the sale abroad of Canadian beer and spirits. The international trade in alcohol is obviously growing apace. Someone should do a study as to why beer and liquor, which can be produced almost anywhere, would ever be traded.

Marketing nuances

The afternoon mostly comprised heavy stuff about the nuances of marketing technology. We were given good insights into just why Canadian advertising is so boring, and how it is that business usually makes such a mess of launching new products. (Lack of brand names with a distinct personality is the reason for the first, and lack of research the reason for the second.) Then we heard why communications between manufacturers and retail outlets are so bad, and why manufacturers should shape up because retailers are becoming agents for the consumer rather than agents for manufacturers. (Manufacturers' agents are disdainful of store managers. Manufacturers will suffer accordingly.)

Finally, Claude Marier of the Société des Alcools du Québec (SAQ), described the evolution of his agency with the times to the point where Quebec consumers are attracted to liquor stores by wine and cheese parties put on by their friendly liquor control board, carrying away their purchases in a bag bearing the legend "La modération a toujours sa place." Other marketing devices include wine festivals, 70 house brands of wine, and a hotel and restaurant hotline.

The afternoon sessions were not of immediate interest for observers from the other side of the fence, but they nevertheless contained stuff that we should know about. What is the use of a theory of alcohol use that cannot explain why Chivas Regal can cost 70% more than regular Scotch, taste no different, and yet still survive in the marketplace? Can the upswing in alcohol abuse among middle-aged, home-bound women have anything to do with the vogue for including alcoholic beverages as recipe ingredients for commonplace meals — a trend much encouraged by the SAQ?

The day ended with a customary reception put on by a wine company. (The pre-lunch reception had been courtesy of Brewers' Retail.) Chateau-Gai Wines used the occasion to introduce Canada Cooler, a beverage conference organizer Robert Shoniker described as an "adult soft drink."

It comes in non-refundable versions of the 12-ounce (341 ml) bottles used for Labatt's Classic Beer (Labatt's owns Chateau-Gai), is likewise sold in six-packs, but at $6.45 rather than $4.70 even though the alcohol content is lower — 4.5% rather than 5.0%. The label reads: "Wine Drink," and "A refreshing tasting drink of white wine and sparkling mineral water, flavoured with the tang of citrus." It tasted like a fizzy fruit punch.

Such drinks are a marketing wave of the future, we were told, very popular in California — a place where wine bars in laundromats are all the rage, controlled by a franchise operation with the slogan "Have some suds while you do your duds." My concern is that if these adult soft drinks catch on, and the price comes down, they will be especially conducive to excessive consumption, particularly among young people. Solid research has shown that sweetening alcohol, or otherwise making it more palatable, is a good way of inducing excessive use.

Researchers and others with an interest in the consumption of pharmacologically active beverages should take an interest in what the beverage marketing business is doing and spend some time at next year's Beverage Marketing Seminar.

NEWS

Anabolic steroids reaching down to junior high athletes

By Jon Newton

WEST LAFAYETTE, Ind — The use of anabolic steroids to improve athletic performance has reached junior high school level and could seriously affect the health of growing children, warns David Lamb, PhD, author of the United States Olympic Committee's position on drug use.

Dr Lamb, professor of physical education and health at Purdue University here, told **The Journal**: "My knowledge of this comes from people who have called me personally, and also through my contacts from the American College of Sports Medicine.

"Each of them quoted several cases of people who wanted to know either how to get steroids, even down to junior high school level, or how to monitor them. So it seems to me that if I, as one person, am hearing about it, there's probably a lot of steroid use going on with school children."

Currently, the most widely-abused drugs are androgenic-anabolic steroids (containing the male sex hormone, testosterone) and synthetic analogues. These are injected, or swallowed in tablet form.

Hard figures as to the actual prevalence of the drugs are difficult to come by, says Dr Lamb, but informal surveys and evidence from former users and people closely associated with athletes suggest the drugs are used by between 80% and 100% of adult national and international competitors.

Male body-builders, weight-lifters, shot-putters, discus and hammer throwers, and javelin competitors appear to be the main abusers, but steroids are also being taken increasingly by school children with the knowledge and approval of "misguided" coaches and parents, he says.

Dangerous side effects in adults are well documented. Athletes who use steroids risk developing serious liver disorders, jaundice, kidney failure, impotence, hypopituitarism, and a host of other potentially serious complaints, says Dr Lamb in a recently published report.*

Some women athletes who decide on a course of androgenic-anabolic steroids can expect severe effects including hair on the upper lip, chin, and cheeks, baldness, deepening of the voice, shrinkage of breasts, uterine atrophy, and irregularity or cessation of the menstrual cycle.

Furthermore, animal studies indicate that steroids are, at the very least, "weak carcinogens that can initiate tumor growth or promote such growth in the presence of other carcinogens," states Dr Lamb.

There is already one recorded instance of an athlete's death from liver cancer after using anabolic steroids. A report in the January US *Annals of Internal Medicine* discusses a 26-year-old weight-lifter who had taken steroids on and off for about four years.

Dr Wylie Overly, the Pennsylvania physician who wrote the report, said although there was no positive proof the drugs were responsible for the weight-lifter's cancer, ". . . it's pretty well established that these drugs are carcinogenic, and it certainly has to be suspected."

And he hopes the case will serve as a warning, "particularly to young people."

In children, steroids are known to cause virilization, feminine breast development in both sexes, and premature fusion of the growth plates in long bones, which can result in irreversible short stature.

Coaches: knowledge, approval

Moreover, "if taken by pregnant women," warns Dr Lamb, "steroids may inhibit the development of the female embryo, cause pseudo-hermaphrodism, and (may) even cause the death of a fetus."

**Anabolic steroids in athletics: How well do they work and how dangerous are they?* David R. Lamb, PhD, Department of Physical Education, Health and Recreation Studies, Purdue University, West LaFayette, Indiana.

Eight studies support hypothesis

Cervical cancer/cig tie tighter

By Jean McCann

DAYTONA BEACH, Fla — New epidemiologic evidence reinforces a link between cigarette smoking and cervical cancer.

This is based on several separate studies revealing an independent association of abnormal cervical changes, as well as actual cancer, with both a large number of sexual partners and with cigarette smoking, Warren Winkelstein told the annual science writers' seminar here sponsored by the American Cancer Society.

Dr Winkelstein, professor of epidemiology in the department of public health of the University of California, Berkeley, told **The Journal** that analysis of these studies supports an original hypothesis he made in 1977: "that cigarette smoking would be causally associated with cervical cancer, and about eight studies have been done since then that have supported that hypothesis.

"All of these studies have also taken into account other known risk factors such as age, social class, and number of sexual partners.

"I think the evidence is now quite strong that cigarette smoking takes its place along with multiple sexual partners as the most important risk factor for cervical cancer."

Dr Winkelstein explained that "the mechanism is the absorption of a chemical carcinogen from cigarette smoke, with circulation through the blood system to the tissues of the body."

When this happens, body cells particularly susceptible to the carcinogen, such as those in the cervix and lungs (both are called squamous epithelium) are transformed into cancerous, or precancerous, tissue.

Because of these findings, he said, he has begun another study to see if cigarette smokers get more skin cancer than others. Skin, like the cervix and the lung, has the same type of surface, the squamous epithelium.

Dr Winkelstein noted that skin cancer, the most common human cancer, has never before been studied with respect to cigarette smoking, although cancer of the lip has previously been associated with smoking pipes and cigarettes.

He added that further evidence linking cigarette smoking to cervical cancer is that women with this type of cancer have also developed separate, primary tumors in the lung, implying a common factor, in this case cigarette smoking.

France's 'Mr Anti-Drug' focuses on prevention

By Harvey McConnell

ATLANTA — In less than a year Franck Perriez has catapulted from an anonymous, apolitical professional civil servant, to France's "Mr Anti-Drug," and a media celebrity.

He was appointed seven months ago by President François Mitterand to coordinate all government ministry efforts as France launched its own war on drugs.

Now Le Président, Mission Interministérielle de Lutte contra la Toxicomanie, Mr Perriez became known to the media last summer when, as a department of justice official, he worked with the president of Club Meditérranée to provide holiday camps for poor children.

Of that venture, he says: "It is the first time in France we have associated a private organization and the government in such a way."

Publicity from the venture's success obviously influenced President Mitterand when he settled on a choice of a director of the government's war on drug use and abuse.

Now, each week, Mr Perriez goes to the Elysée Palace to report directly to one of President Mitterand's closest advisers (President Mitterand has the office next door), reflecting the President's personal concern about France's drug problems.

Mr Perriez told **The Journal** he receives telephone calls each day from distraught parents pleading for help. "They tell me they don't know what to do. Their son is an addict, they need help," he said.

To find out what is being done in the United States, Mr Perriez recently spent time in Washington with Carlton Turner, PhD, director of the White House Office on Drug Abuse Policy, and officials of the National Institute on Drug Abuse and the Drug Enforcement Administration. He came to Atlanta to attend the international conference here of the PRIDE parents organization.

Mr Perriez says he would like to set up parent groups concerned with prevention and treatment, but admits it may be a daunting task.

He explains: "At present, we have only two small parent organizations made up exclusively of parents whose children are addicts.

"In France, many people feel that all programs must be run by the government. I think that is impossible; there must be family and individual responsibility.

"We are now ready to create such organizations by grouping families with them, but it will not be on the same model as in America, where the spirit is different than in France."

While France "is about five years behind the US" in its drug patterns, it is catching up fast: cocaine is becoming the siren song of the Paris elite.

Mr Perriez said heroin is a major problem in the regions around Paris and Marseilles, and in eastern parts of the country with easy access to Belgium, the Netherlands, and West Germany. Most addicts are men, aged 16 to 30, he said.

"In France it is different in some ways. Heroin addicts are in two groups: about 50% are not employed and the other 50% are mainly white collar workers. Heroin is used by all classes in our society," he added.

Glue sniffing is a problem in big-city suburbs but the extent is hard to evaluate. Marijuana use is widespread, even among pre-teens.

President Mitterand (left): he's personally concerned, says France's drug chief. In Paris (above) heroin is a big problem.

Cocaine is now replacing Scotch as the "in" thing among the Parisian chic.

Mr Perriez: "At the moment, it is used mainly by people in showbiz and high society. At some Paris dinner parties a line of cocaine is served from golden spoons."

Although bashful about discussing his media popularity, Mr Perriez admits: "I do have good relations with the media.

"I think this is important because every minister has his own ideas about what should be done about the problem by his department. I coordinate efforts by all the ministeries, and it is important for the media to know one man can speak about all the problems.

"And it is important, as well, in giving credence to our policies, and to demonstrate that we speak publicly about the problems."

For many years after the closure of heroin processing labs in southern France — the French Connection — most people in France, as in the rest of the world, thought of drugs as strictly a United States problem. No more.

"The French press today write more than just about the price of heroin or cocaine. Now they talk about prevention. The attitude of people has changed; now most are concerned about our drug problems," Mr Perriez adds.

"I can see many similarities about how our countries (US and France) approach the problems, and our policies are moving in the same direction."

Canadians rank 16th on world drinkers' chart

HALIFAX — Canadians are the sixth heaviest drinkers of spirits in the industrialized world, says a report from Health and Welfare Canada.

Although consumption of spirits declined by 2% between 1975 and 1980, Canadians are outranked in this category only by Poland, East Germany, Hungary, Japan, and Czechoslovakia. The average consumption was 3.4 litres of absolute alcohol per capita annually in the form of spirits (about 198 average drinks per year).

The report, *Alcohol in Canada. A National Perspective*, also shows Canada ranked 12th in beer consumption (267 beers/year) and 28th for wine (69.5 glasses/yr) of the 35 countries surveyed.

Canada was 16th overall in annual consumption of alcohol per capita in 1980 (the latest year figures are available). This amounts to an average 9.1 litres of absolute alcohol per Canadian, or 11.27 litres for those aged 15 and older.

France, with per capita consumption of 14.8 litres of absolute alcohol, had the highest consumption rate, while South Africa, at 3.8 litres, was the lowest. The United States was slightly below the Canadian rate with 8.7 litres.

Other countries in the top five, with their average per capita consumption rates in brackets, were: Spain (14.1 litres), Italy (13.0), West Germany (12.7) and Hungary (11.5). (See chart below)

These estimates of alcohol consumption were based on sales records of alcoholic beverages, the report says. Beer accounted for 50% of all alcohol consumed in Canada. Spirits made up 37% and wine 13%.

Between 1975 and 1980, beer and spirits consumption declined throughout Canada as a whole, while wine jumped by 47%, the report says.

"While consumption appears to have stabilized from 1978 to 1980 for Canada as a whole," the report states, "it is too early to tell whether this represents a significant ongoing change, or merely a temporary alteration in a general trend of increasing consumption."

Among the four highest alcohol-consuming regions in Canada, Alberta showed a 12% increase in per capita consumption between 1975 and 1980. The Yukon increased by 6%, British Columbia by 2%, while the Northwest Territories reported a 9% decrease.

In the middle-ranked provinces, Ontario remained stable, Newfoundland and Prince Edward Island each increased by 4%, and Manitoba declined by 3%.

In provinces with lower ranked consumption, Nova Scotia and New Brunswick increased by 7% and 4% respectively, while Saskatchewan and Quebec dropped by 3% and 4%.

Although Canadians' attraction to drinking seems to have stabilized, alcohol still accounted directly or indirectly for one in every 10 deaths in Canada in 1980.

Per Capita Alcohol Consumption in Various Countries, 1980

Position	Total	Spirits	Wines	Beer
	— litres of 100% alcohol per inhabitant —			
1. France	14.8	2.5	95.4	44.3
2. Spain	14.1	3.0	64.7	53.4
3. Italy	13.0	1.9	93.0	16.7
4. West Germany	12.7	3.1	25.6	145.7
5. Hungary	11.5	4.5	35.0	86.3
6. Argentina	11.4	2.0	75.0	7.7
7. Austria	11.0	1.6	35.8	101.9
8. Portugal	11.0	0.9	70.0	33.8
9. Belgium	10.8	2.4	20.6	131.3
10. Switzerland	10.5	2.1	47.4	69.0
11. Australia	9.8	1.0	17.4	134.3
12. East Germany	9.7	4.5	9.5	135.0
13. New Zealand	9.7	2.5	11.0	118.0
14. Czechoslovakia	9.6	3.5	15.5	137.8
15. Denmark	9.2	1.5	14.0	121.5
16. Canada	9.1	3.4	8.5	87.6
17. Netherlands	8.8	2.7	12.9	86.4
18. Poland	8.7	6.0	10.1	30.4
19. U.S.A.	8.7	3.1	7.9	92.0
20. Romania	7.9	2.3	28.9	43.0
21. Bulgaria	7.5	2.0	22.0	57.7
22. Ireland	7.5	2.0	4.5	121.8
23. Yugoslavia	7.4	2.0	27.3	44.2
24. U.K.	7.1	1.8	7.2	117.1
25. Greece	6.7	—	44.9	26.4
26. Finland	6.4	2.8	8.2	57.4
27. Chile	6.2	—	45.0	15.0
28. U.S.S.R.	6.2	3.3	14.4	23.1
29. Sweden	5.7	2.8	9.5	34.1
30. Japan	5.4[1]	3.9[1]	0.6	37.8
31. Cyprus	4.8	2.0	9.8	32.4
32. Norway	4.6	1.9	4.4	48.3
33. Uruguay	4.5	—	25.0	30.0
34. Iceland	3.9	2.3	5.5	16.0
35. South Africa	3.8	1.3	8.8	28.6

[1] Includes 15% saké

Source: *Report 82*, The Swedish Council for Information on Alcohol and Other Drugs (Stockholm 1982) and *Alcohol in Canada: A National Perspective* (Health and Welfare Canada, 1984)

'I walked three-and-a-half blocks for a glass of milk'

Setbacks fuel octogenarian's war on drink

By Jon Newton

TORONTO — Take equal parts of grapefruit juice and tonic water, add ice cubes, and you've got a Bill — not a Shirley — Temple. A measure of vodka turns the drink into a Wild Bill Temple. At least, that's what ex-Toronto mayor John Sewell says in his *Globe & Mail* column.

The vodka certainly *would* make Bill Temple wild, for this 85-year-old former World War I pilot is probably Toronto's (if not Canada's) foremost anti-alcohol crusader and the man who is spearheading a battle to keep this city's only "dry" area, dry.

At the beginning of April, more than half the eligible voters in West Toronto turned out in snow and bitter cold to issue a firm "No!" to plans to grant licences for local restaurants to sell liquor, wine, or beer.

West Toronto, by an "honest, democratic vote of the people," as Mr Temple puts it, went on the wagon more than 80 years ago when it agreed to become part of the City of Toronto only on the condition that it remained solely responsible for its own liquor regulations.

It's been liquorless ever since — three attempts to change the status quo in 1966, 1972, and in April, notwithstanding.

Volunteers in the polling stations this April said they'd never seen so may people making the effort to be counted in a plebiscite. Many of them attributed the turn-out to Mr Temple.

He was the man, say volunteers, who persuaded almost 8,500 West Toronto people (half of them women estimates Mr Temple) to brave the elements at 113 polling stations.

More than 60% of area voters decided against allowing liquor into the community. The anti-booze crusaders were victorious.

At least that's how it seemed.

In March, however, the Liquor Licence Board of Ontario (LLBO) had quietly ruled that the south side of a street in the area — Bloor Street between High Park and Jane streets — was, in fact, already "wet," because it was once in the Township of York, not West Toronto.

And, at the end of April, Toronto City Council, against the majority of residents' wishes, decided to open a door that had been closed for more than eight decades. They decided not to block applications for licences along that stretch.

Newton

Temple: television tells two million people every night to drink

Already, six business have applied for liquor permits in the strip, Alderman Bill Boytchuk, who wanted the permits refused, has told City Council.

It's exactly what Mr Temple was afraid of. He sees the process as an inevitable precursor to the granting of any number of alcohol licences in the area, a situation which occurred on a nearby avenue — Roncesvalles — when it was given permission to serve alcohol.

Now, 10 years on, there are 14 licences on Roncesvalles, "and it's not safe for women to go out in the street at night because of the drunks," Mr Temple told **The Journal**.

Not surprisingly, he does not intend to take the City's current about-face lying down; he plans to appeal the decision in court.

"This is a political fight," he said angrily. "We suspect they knew they couldn't win by an honest, democratic vote of the people. So they cooked the boundary lines after 84 years. The LLBO wouldn't give licences on Bloor South, but now they've suddenly and conveniently unearthed a new line which shows it's wet.

"But it's always been recognized as dry, and our maps show it that way."

Although the pro-alcohol contingent, including, one suspects, the occasional brewer and distiller, would no doubt prefer it if Mr Temple turned his attention to growing roses, he says: "I'll keep on being active.

"The news media can't do much — they're bribed by $100 million worth of liquor advertising NOT to tell the people what's really going on."

Small, and neat in his carefully-pressed business suit, he's been agitating for the temperance movement since the beginning of the century. He tells with a dry chuckle of the time he was fired after two decades as an executive with a famous clothing manufacturer.

"I was a bigoted, very loyal Tory. Then I did a switch. I became a rabid labor supporter. I became an enthusiastic socialist.

"I was in Kitchener in 1933. It was a Liberal town then, still is I guess, so I got called into the head office. My former boss had retired, and the new man called me in and said, 'Bill — I don't know what socialism is, but I don't think it's in the interests of the company.' "

Mr Temple took the hint and started up his own business, representing European clothing manufacturers in this country.

But it was after he dropped his political stance as a socialist member of the Ontario Legislature in 1948 that he began in earnest as an anti-alcohol lobbyist.

When he says alcohol is "the scourge of the world," he means every word. And he is passionate in his condemnation of politicians, both alive and dead, whom he believes were responsible for allowing the brewing and distilling industries to gain a firm foothold in Ontario and Canada.

"I was brought up in the belief that alcohol is a curse and a menace," he states, "and I saw much to prove it in the armed forces. One of the first buildings to go up was always the wet canteen. In fact, some air force stations didn't even have dry canteens. The only place the boys could go was to get drunk. That's where all their money went."

Education is not the answer to the current problem, he says. "You've got to fight! Alcohol is killing more people than ever in our Western society. All the wars of history can't match it.

"If I had carte blanche to do whatever I wanted, I would immediately prohibit alcohol advertising to start with — all of it.

"Then I'd start eliminating licences. Any drunkenness in a restaurant and I'd cut the liquor off, and I'd cut it off in all parks and arenas.

"One of my favorite statements is: 'the Davis government (of Ontario) is the best friend the brewers and distillers ever had in the history of Ontario. They give out 1,000 new licences every year.' I recently walked down Parkdale (a nearby "wet" area) for three-and-a-half blocks before I could get a glass of milk.

"But I could have bought booze on every corner, and in between. It's all over the place.

"In Metro Toronto, there are 37 taverns with so-called entertainment nightly. The dancing girls have got no clothes on and they get up in front of half-drunk men, mostly young men, and we all suffer for it.

"Nowhere do you see that the solution to drinking and the associated slaughter on our highways could come from the reduction of the number of liquor outlets in the province, and Canada as a whole, and in the amount of advertising which is permitted. But we don't hear a word from the government. We only hear about stricter penalties and more policing."

But, he believes the pendulum is slowly swinging the other way, as the recent vote demonstrated.

"The people turned out to vote. We had a better turnout for that liquor plebiscite at a rotten time of year than they get in a municipal election.

"The Ontario Temperance Federation used to boast that it could reach 3,000 people in a single meeting. But, my gosh, television reaches two million people every night, telling them to drink.

"That's success, and that's what we're up against."

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Gandhi's anti-drink lesson guides India's Blue Cross

I was very much delighted to read the call of Dr Everett Chalmers (**The Journal**, April) to all professionals to teach the public about the evils of drugs. It is in the same way that Mahatma Gandhiji, the Father of the Indian Nation, also appealed to the public in his journal *Harijan* dated 18-9-1937. He wrote that each and every one should take up the propaganda against the evils of alcohol to the people at least an hour every day. Though I am a university teacher, I do this service in India because I appreciate the message and find it very, very useful.

You may be interested to know that the Blue Cross Society of India, which is one year old, helps people with alcohol problems.

This year, for the first time, in association with the traditional Chitrai Festivals in Madurai, it held an exhibition. Every day, an estimated 6,000 people visited the pavilion throughout the exhibition, from April 7 to May 20. Thousands of people benefited.

S. Selvin Kumar
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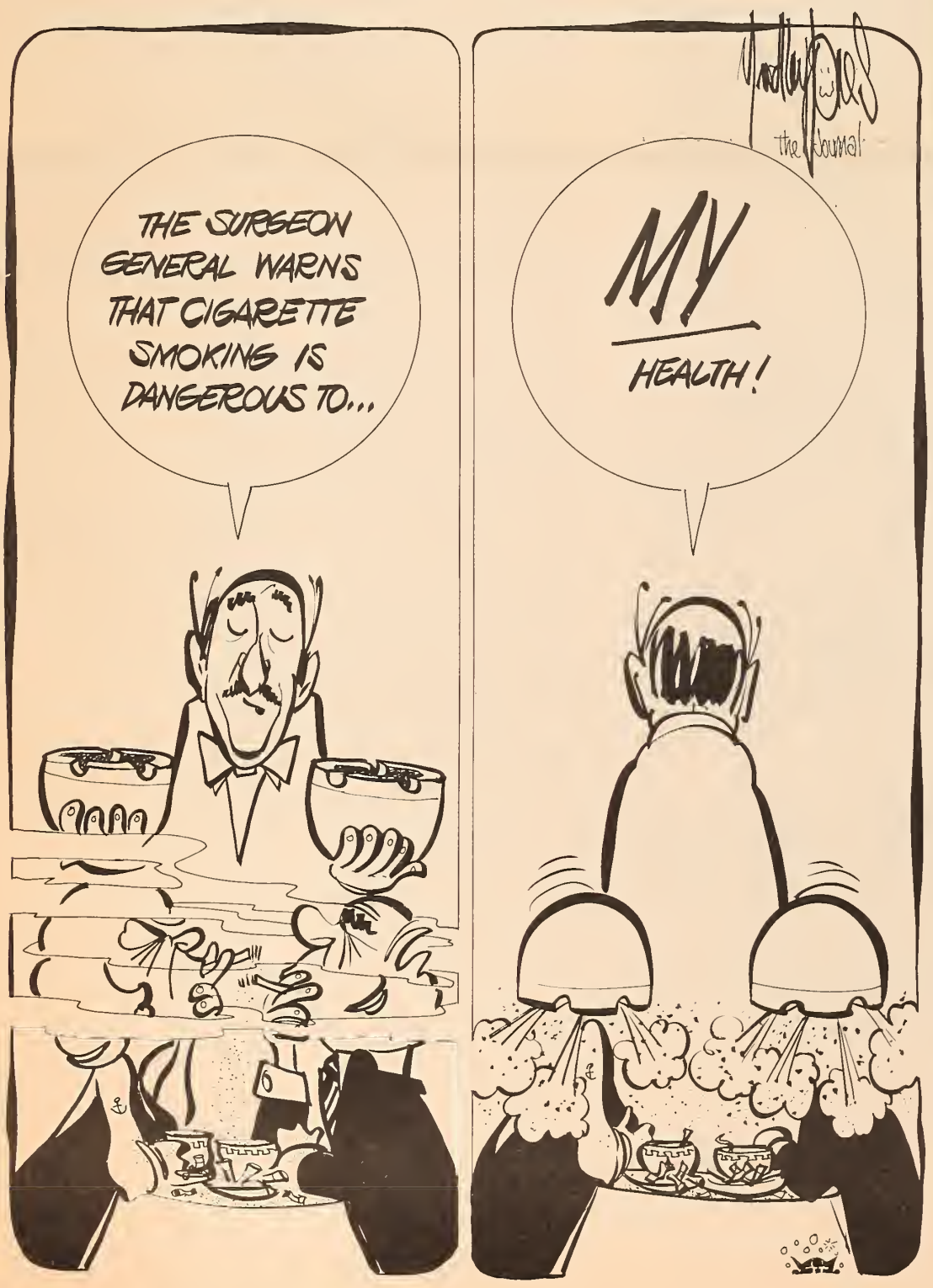
Blue Cross exhibit in Madurai: 6,000 visitors a day



Peele elaborates on people's quitting habits

The summary of my talk (**The Journal**, Feb) was quite excellent. However, there was one misprint which creates quite the wrong impression. In George Vaillant's study of outcomes for inner city alcohol abusers, 20% were moderating their own drinking; of the 34% who were abstaining, 63% (and not 3% as typeset) had done so without AA (Alcoholics Anonymous). (Vaillant defined abstainers as drinking less than once a month.)

The context of my remark — "there is something very similar about asking a behavior therapist how to do something and asking God, because both also always tell you the hardest way" — was in reference to a text by distinguished behavior therapists Roy Hodgson and Peter Miller, entitled *Self-watch*.

In that book, the only person described who didn't rely on behavioral technology to quit smoking was one who had a religious experience. This is in contrast to a recent estimate by the American Cancer Society that 95% of those who quit smoking do so on their own, most probably employing less elaborate or cataclysmic methods.

Stanton Peele, PhD
Morristown, New Jersey

Children's exhibit photo effective

I want to thank you for the excellent coverage that you gave the Children of Alcoholics Foundation and our Providence and Boston art shows in the March issue of **The Journal**.

The photograph on page 12 was quite effective.

We hope to continue sending you Foundation news and we'll look forward with pleasure to seeing it in **The Journal**.

Irene R. Bush
Director
Children of Alcoholics Foundation, Inc
New York, NY

'Unhealthy ads' deceptive

I am very interested in obtaining more information about BUGA UP (Billboard Utilising Grafitists Against Unhealthy Promotions) in Australia.

Our society has too long allowed this deceptive invasion into our lives and the lives of our highly impressionable youth.

Could you let me know how to contact this group — an address or contact person?

John Wallace
Principal
Port Dover Composite School
Port Dover, Ontario

Editor's note: *BUGA UP may be contacted through Arthur Chesterfield Evans, 58/11 Yarranabbe Rd, Darling Point, 2027, New South Wales, Australia.*

FEATURES

Documentary focuses on 'the hidden victims'

Cousteaus probe the heart of coca country

By Harvey McConnell

ATLANTA — The most profound environmental issue today in the vast Amazon river basin in South America is coca bush cultivation for cocaine extraction.

Jean-Michel Cousteau was so affected by what he and his father, Jacques Cousteau, found on a trip up the Amazon that they produced a special documentary for airing on United States television this fall.

While Mr Cousteau's father and the yacht Calypso sailed from the mouth of the Amazon to Iquitos, Peru, more than 2,000 miles inland, Jean-Michel travelled 1,800 miles in the other direction from the source of the Amazon to Iquitos.

"We were constantly reminded of the presence of coca bush plantations which are being developed on the eastern flanks of the Andes," Jean-Michel Cousteau told the international conference here of the PRIDE parents organization.

"For months and months while we were there we were approached in different ways to cooperate, or consume, or, perhaps, it was implied, to be transporters (of cocaine). We were put under certain threats from one country to another."

Mr Cousteau said the expedition was to explore the Amazon. But, "were we going to put this aside and ignore it, or are we really talking about an environmental issue, (although it's one) which does not affect little fish or little plants?

"Do we know this side of the world — and, in a major way (are we) responsible for what happens out there — do we really know what happens out there?"

Mr Cousteau flew to Atlanta to talk with officials of a cable television network which had contracted for six hours of programming on Jacques Cousteau and his work. Jean-Michel explained what was going on, said the Cousteaus believed they had something to contribute, and immediately arranged for backing for a documentary.

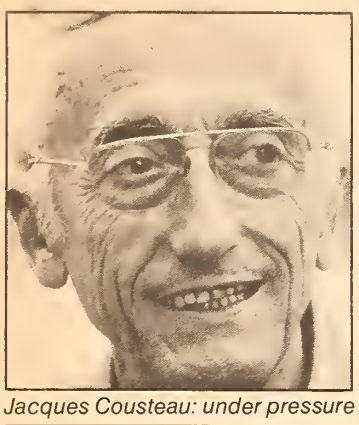
With the help of US officials, including Carlton Turner, PhD, director of the White House Office on Drug Abuse Policy, and the Peruvian government and local officials, "we were able to go places where, had we not had this support, we would never have come back."

Mr Cousteau said the hour-long documentary only scratches the surface "because the more we went into the problem, the more we found it was endless.

"We have focused on the hidden victims. We are not interested in the politics or the economics, although they are linked, but in the people who are paying the bills, people who are losing their lives, people who are not able to know what really is happening, because nobody has told them, or because a lot of people take advantage of them."

It works the same way on the other side of the world; producers will grow more and more as there are more and more consumers, and the consumers are victims as well, he said.

"Looking at the two extremes, they are closely related, and they don't know each other. They don't know the existence of each other. They don't know the sacrifices which they go through as this formidable machinery is taking advantage of those on each side," he continued.



Jacques Cousteau: under pressure

Indians whose culture included chewing coca leaves are now under incredible pressure by outside influences. They are being forced to switch to only one crop — the coca bush. Many are now slaves to the trading post, or the company store, where their bill is always more than they earn from coca leaf crops.

Jean-Michel Cousteau: the more we went into the problem, the more we found it was endless

Mr Cousteau: "As you fly over, you are absolutely amazed by the coca plants growing on the low flanks of the Andes. You see concrete airstrips, built in one month, for jets to fly in to take away tons of coca paste."

And there is "always — always —the threat of violence. People are threatened. People are scared. People live on the edge of life all the time."

One scene in the documentary shows an 18-year-old Indian girl, with a one-month-old baby, who was sentenced to 10 years in jail for carrying coca paste from one bus station to another.

The baby was left on the street.

"These are the victims," he declared, "the ones we never talk about. The little people.

"Another aspect we were totally overwhelmed about is that the pits used to produce coca paste are draining into and polluting the river."

Mr Cousteau recounted stories of a number of people with whom he and his crew met and talked. "I have met an unbelievable number of young people, wonderful people, who have confessed to stealing from their mother, father, family, school teacher, any way possible, to buy coca paste," he went on.

"We found one man who consumed *80 to 90 coca paste cigarettes every night* . . . We met a former engineering student in a jungle town who would do anything for a coca paste cigarette.

"His departing words were: 'You show this to them out there. If they don't believe it, you tell them to come and see me. I am a wreck. I don't even remember my age.' "

There are no statistics on the little people selling coca paste cigarettes, but they must be in the tens of thousands. Most farmers don't know what they are doing, said Mr Cousteau, they just know there is a growing demand for coca leaves.

He said the West must remember the Chinese opium wars at the turn of the century and what they did to Chinese culture.

"We are seeing the same thing happening out there, and we cannot let it go by without showing what we have seen," he added.

The principles for which the US stands, and the pride with which they are projected around the world, are "being put under tremendous pressure, I believe."

Thousands of people are being sent to jail, or threatened or killed, and they don't know why. "Lives are screwed up and they don't know why."

Alcohol legislation at local level has advantages

By Lynn Payer

NEW YORK CITY — Supporters of a city law here requiring bars, restaurants, and liquor stores to post warnings that alcohol drunk during pregnancy can cause birth defects, sometimes held up a book to make their point.

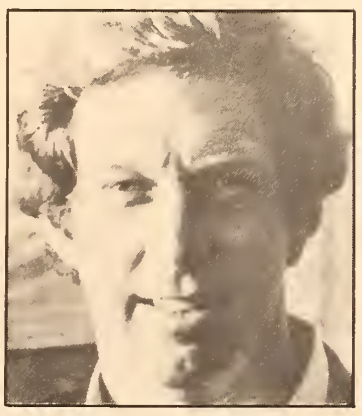
The book was *Will America Sober Up?** by Allan Luks, executive director of the New York City Affiliate, Inc, of the United States National Council on Alcoholism.

In the final chapter, Mr Luks suggests the first step in sobering up the United States would be labels on alcohol bottles warning pregnant women.

The New York City law passed, and Mr Luks believes it may be partly because information has a greater impact when packaged in a book.

"The liquor industry flew lobbyists in from all over, from the biggest law firms. Yet we got this bill," said Mr Luks. "The alcohol industry doesn't have its own book."

The New York Times Book Review compared *Will America Sober Up?* to two other publications whose impact went far beyond their sales.



Luks: governments waiting

They were Michael Harrington's *The Other America: Poverty in America*, which persuaded then-president John Kennedy to launch his war on poverty, and Ralph Nader's *Unsafe at Any Speed*, which helped spark the consumer movement.

But Mr Luks, a lawyer and pragmatist who believes in seizing the moment, also believes the New York law (**The Journal**, April) passed because the moment was right. And he wrote his book now because he believes concerns about alcohol fit the American health-consciousness.

"The public wants and welcomes a great amount of government involvement in the alcohol field," he said. In Gallup polls, alcohol — and what the government should be doing about it — consistently rank above other health concerns such as smoking, diet, and exercise.

While governments usually lag behind public demands to regulate alcohol, he said, and the national government under President Ronald Reagan is unlikely to act, "local governments are waiting for us to knock on their doors."

Another advantage to legislating at local levels is the liquor industry cannot keep up with the number of bills being passed in individual cities and states, he continued.

The New York bill has been opposed not only by the liquor industry, but also by certain New York feminists, in particular the New York chapter of the National Organization for Women (NOW).

New York NOW says the bill singles out pregnant women for the warning when, in fact, birth defects are not the chief problem caused by alcohol.

Mr Luks points out that many women, a number of whom could be considered feminists, strongly supported the bill. He defends the narrowly-based warning on the grounds a more broadly-based one would probably not have passed.

The fact drinking during pregnancy can cause birth defects is not as generally known, Mr Luks explains, so a narrowly focused warning on this point can be more easily defended.

As well as chapters on non-alcoholic wines ("they are remarkably tasty but have a distribution problem") and a sober-up pill, and asides about the machinations of the alcohol industry to defeat regulation attempts, Mr Luks discusses the more controversial areas of a test for alcoholism and of compulsory treatment.

To critics who might charge that coercive treatment and government action in alcoholism comes too close to the Orwellian concept of Big Brother, Mr Luks points out that George Orwell in his classic, *1984*, talked about a society where the cost of all goods — except liquor — kept rising.

Orwell wrote: "*There had never been quite enough to eat, one had never had socks or underclothes that were not full of holes, furniture had always been battered and rickety, rooms underheated, tube trains crowded, houses falling to pieces, bread dark-colored, tea a rarity, coffee filthy-tasting, cigarettes insufficient — nothing cheap and plentiful except synthetic gin.*"

**Will America Sober Up?* Allan Luks, published in the US by Beacon Press Books, and in Canada by Fitzhenry & Whiteside Limited, Toronto.

WARNING

Drinking alcoholic beverages during pregnancy can cause birth defects

Poster: the message to New York City women

INTERNATIONAL

Traditional controls meet 'the modern era'

Chinese 'immunity' to alcoholism being tested

By Dorothy Trainor

TORONTO — China's vast population has been considered a light drinking society, but this may be changing, says the Honorary President of the World Federation for Mental Health.

Tsung-yi Lin told the annual meeting here of the American Orthopsychiatric Association that events in China are of global interest, and suggest a need to redefine perspectives in the fight against alcoholism.

"The century-old reputation of 'Chinese immunity' to alcoholism seems to be encountering a growing challenge from reports of its significant increase within Chinese communities in Hong Kong and Taiwan," Dr Lin states.

"The protection of the Chinese from alcoholism has been attributed to two major factors."

One is the constitutional hypersensitivity of Orientals to ethyl alcohol due to an inborn enzyme deficiency in metabolizing acetaldehyde. "As a result, the Chinese are very sensitive to alcohol ingestion, showing red face, palpitations, nausea, etc.

"The other is the sociocultural control mechanisms of the Chinese society with its institutionalized pattern of drinking and its traditional cultural and philosophical emphasis on self control."

However, Dr Lin — professor of psychiatry at the University of British Columbia — says there is no reassurance that these protective biogenetic and sociocultural mechanisms will continue to shield the Chinese from alcoholism.

In fact, he says Chinese communities both on and off the mainland are changing greatly as they enter the modern era.

Changing patterns: 'there is no reassurance that the protective mechanisms will continue'

Therefore, whether the Chinese will continue to be at low risk for alcoholism is not only pertinent to the Chinese, but is also a question of scientific concern to a world lacking effective controls.

"It is of special interest to note that the two ethnic groups that stand at the opposite ends of the spectrum of vulnerability to alcoholism in North America share certain important characteristics with the Chinese," he continued.

"The American Indians, probably the most vulnerable, have the same constitutional hypersensitivity to alcohol as the Chinese; the Jews, reputed to be the least vulnerable, have a sociocultural tradition emphasizing moderate drinking similar to the Chinese."

Alcoholism is an international problem and should be approached thus, he said. International efforts must be guided by a global vision seeking to understand the nature and operation of particular indigenous forces — social, cultural, and political — and their interactions.

Smoking ban in Israel is producing little change

By Michael Kesse

TEL AVIV — Vociferous public discussions about the new law banning smoking in public places here, which went into effect on February 1, have died down.

But so far there has been little reduction in smoking in buses, elevators, cinemas, theatres, libraries, pharmacies, hospitals, clinics, and so on. Where the "No-smoking" signs were formerly honored, they still are. And where they were ignored, they are still being ignored (**The Journal**, Nov 1983).

Perhaps the biggest change is that anti-smokers now at least have the law on their side. Formerly, they could only ask the public to respect "no-smoking" signs displayed prominently in most public places.

But, after a short spurt of filing reports, attended by much publicity (each person found guilty must pay a $35 fine), police and municipal inspectors turned to more pressing matters like parking on sidewalks; double parking in "no-stopping, high fine, tow-away" areas; jaywalking, speeding, tailgating, and illegal passing.

Pro-smokers, in a series of letters and articles to the press, have defended themselves on the grounds that Israel has adopted a law which it can never enforce effectively.

Other letters point out dangers to the heart, lungs, and to the babies of expectant mothers.

Even Orthodox Jews — many of whom are heavy smokers, although total abstainers on the Sabbath and other religious holidays — have also taken up cudgels against smoking.

A recent edition of *Assia*, a journal devoted to matters of Halakha (Jewish traditional law) and medicine, has such articles as: The effects of Smoking on the Cardiovascular and Respiratory Systems; Smoking and Cancer — Medical Background; Smoking — a Halakhic Review; and Smoking in Public Places.

To reinforce the arguments, *Assia* quotes a ministry of health survey showing that when the Israel Cancer Society began its fight against smoking in 1970, 64% of Israeli doctors said they smoked; in 1975, the percentage had dropped to 33%; and in 1980, to 16%.

"Ten years ago, most doctors in Israel thought they could have little influence in convincing their patients not to smoke; today 91% believe it is their duty to help fight smoking," says *Assia*.

Pro-smokers, however, point to one case where smoking may have saved a woman's life.

A 22-year-old Swiss tourist asked a man to direct her to a particular youth hostel. He offered to take her there but instead tried to assault her. The woman begged for time to "smoke a last cigarette." When she opened her pocketbook, instead of a cigarette she pulled out a penknife and attacked her attacker, stabbing him in the chest.

Duty-free cigs spell cut-rate health hazard

LONDON — Health educator John Catford has called for an end to duty-free tobacco at ports and air terminals because it merely allows "a holiday tide of heart disease and cancer."

Dr Catford, medical officer for Wessex Regional Health Authority, said: "The government pays for campaigns against smoking, yet at the same time permits thousands of people to smoke themselves to an early grave at cut prices simply because they have been abroad. If Ministers seriously intend to combat smoking, they should act now against duty-free tobacco allowances."

He added that the holiday smoke-up was "midsummer madness."

Help for London's young addicts

Youth centre gets cash boost

LONDON — One of the most impressive centres for helping young drug addicts here has been given a £55,000 (Cdn $99,522) cash boost to resolve its immediate financial problems.

The City Roads (Crisis Intervention) Centre in one of this city's poorest areas was rescued by the department of health and social security and the Greater London Council; each gave £25,000, and the Home Office gave £5,000.

At the end of the last year, City Roads reported a 50% increase in young addicts reaching the centre, and the age of clients continued to drop.

Director Giampi Alhadeff said addiction was increasing faster than at any time since the 1960s.

Moreover, with the quality of street heroin improving and the price dropping, the problem was unlikely to abate unless agencies like City Roads had financial security.

After it was announced that the agency's deficit for the year had been wiped out, Greater London Council Grants Subcommittee chairman Andy Harris said: "City Roads carries out invaluable work tackling one of the most distressing circumstances faced by some of London's young people."

The City Roads Centre — at William Gart House, 358, City Road, Islington, London EC1V 2PY — was established in 1978 as a short-stay crisis intervention unit for young multiple-drug addicts in the Greater London area. It is staffed by social workers and nurses and open 24 hours a day.

Clients usually stay three weeks for detoxification, medical care, and counselling. Sometimes they are referred for long-term rehabilitation.

City Roads: logo juxtaposed with Piccadilly night scene

Grad course in addictions for Australia

MELBOURNE — Australia's first specialized graduate course in drug dependence, offering a Graduate Diploma in Social Science (Drug Dependence), was to start here this month.

The program was developed by the School of Social Work of the Phillip Institute of Technology, a vocationally oriented, tertiary educational unit. It is a two-year, part-time course with a limit of 20 students per year.

Applicants need a recognized professional qualification in social work, clinical psychology, psychiatric nursing, or psychiatry, and at least two years' experience in the alcohol/drug field following qualification.

Subjects include drugs in society; effects of drugs; research, prevention and treatment; social responses to drug control; counselling, and program administration.

UK drug council is reappointed

LONDON — British Home Secretary Leon Brittan has announced he is reappointing the Advisory Council on the Misuse of Drugs until December 31, 1986.

The council was established under the provisions of the Misuse of Drugs Act 1971, to review the misuse of drugs in the UK and advise government on measures which ought to be taken.

The council includes a chairman and 28 members (16 new and 12 reappointed from the previous council).

Third World lacks defences against tobacco promotion

By Thomas Land

GENEVA — Third World governments should launch national campaigns discouraging both consumption and production of cigarettes, declares the World Health Organization (WHO).

A persuasive array of arguments by WHO specialists, backed by medical and sociological findings, conclude: "An epidemic of lung cancer can be predicted from the rapidly increasing cigarette consumption in many developing countries."

And, lacking public information programs and legislation prohibiting tobacco advertising and sales promotion, they fear the epidemic will come "within a decade."

Ken Stanley, a WHO cancer scientist here, explains: "In the industrialized world, education and information programs are succeeding. We are urging Third World countries also to persuade people — particularly the young who do not smoke, not to start, and those who smoke to stop.

"In countries where the tobacco companies have already gained a foothold, we are urging a limit on advertising and sales promotion to current levels — with a view to cutting back later."

A WHO discussion paper says in China and India, the two most populous nations, from a quarter to a third of all men smoke regularly by the time they are between 18 and 20 years of age.

Between 1963 and 1975, the overall incidence of lung cancer doubled in Shanghai, China's largest city, where the rate in males is 50.2 per 100,000 — higher than in many North American and European populations.

Statistics like these led the WHO experts to foresee an "epidemic in the making," largely as a result of "highly sophisticated and ruthless campaigns promoting smoking."

In Malaysia, for example, tobacco companies spent $5 million in 1977 on advertising, a WHO study shows. So effective are some campaigns that "cigarette smoking is already the predominant type of smoking in some . . . regions" of the developing world, despite indigenous forms of tobacco use.

As a result, the experts say, "in almost all countries from which data are available, some 50% or more of adult men are dependent on some form of tobacco use."

The WHO blames an estimated 590,000 new cases of lung cancer, and more than one million premature deaths each year, an increasing proportion of them in the developing countries, on cigarette smoking. A study of 1,400 patients in Iran with heart disease showed 98.4% smoked about 25 cigarettes a day, and an Egyptian study of bronchitis patients showed 90% smoked.

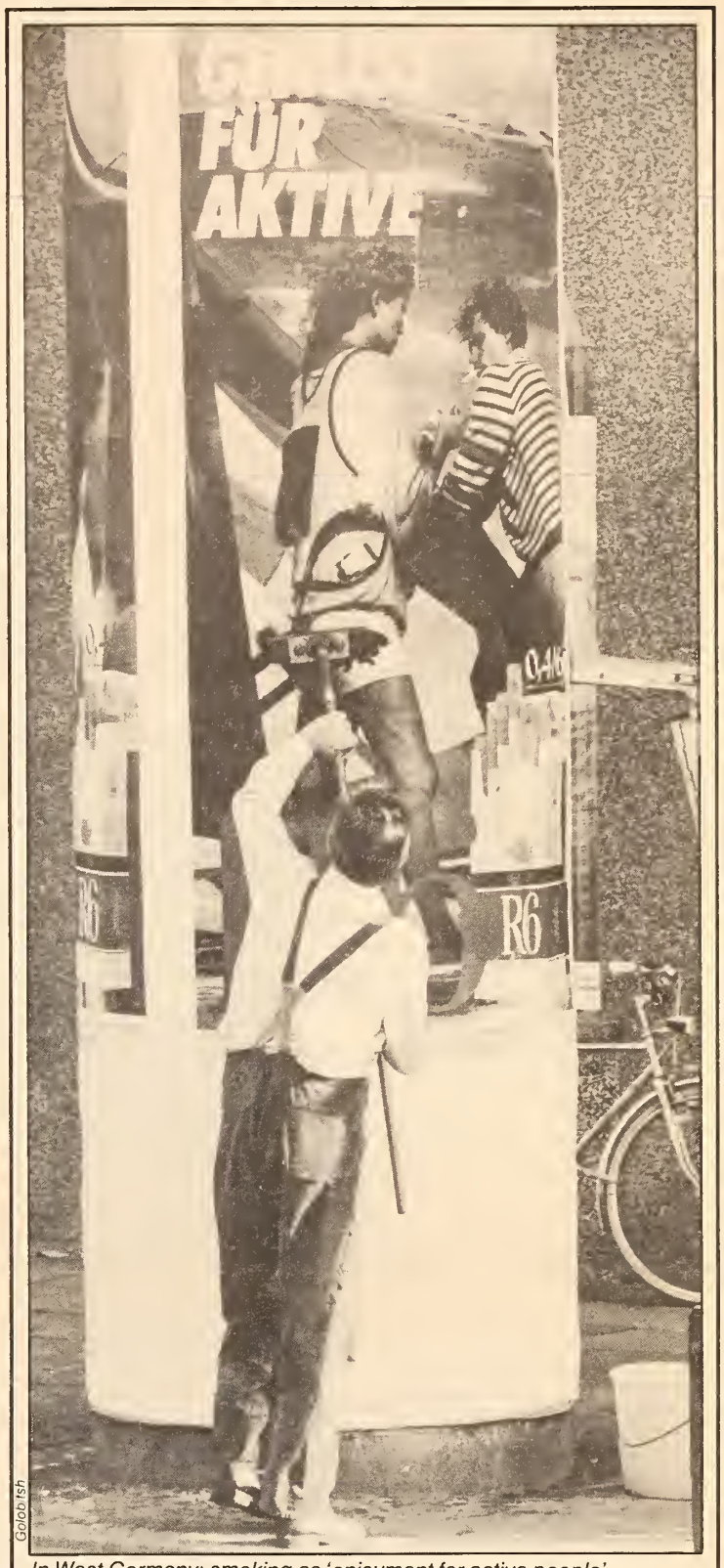
"Smoking is probably the largest single preventable cause of ill health in the world," declares WHO director-general Dr Halfdan Mahler.

In industrially developed countries, smoking is declining among males, but increasing among females. In developing regions, it is mostly men who smoke.

Two exceptions are Hong Kong and Singapore where, the WHO emphasizes, death rates from lung cancer in women "are among the highest in the world."

Overall, tobacco consumption is slowing down by 1.1% yearly in the industrialized countries, while it continues to rise by 2.1% annually in the Third World.

Cigarettes marketed in developing regions deliver significantly more tar and nicotine than those sold in rich countries. In China and India, for example, the tar yield is between 19mg to 33mg per cigarette, compared with 0.5mg and 20mg in most industrialized countries.



Golob'tsh

In West Germany: smoking as 'enjoyment for active people'

Fewer smokers puff more in European community

BRUSSELS — Ten years of anti-smoking campaigns have "obviously borne fruit" in the European community, says an authoritative recent study. But increasing numbers of young people, particularly women, are nonetheless becoming addicted to tobacco.

The European Commission —the secretariat of Common Market countries — puts the number of smokers in the region at about 85.4 million, representing roughly 42% of the population aged 15 years and older.

The figure suggests, says the commission, that 5.7 million people have given up the habit.

Balanced against this, however, is the fact total cigarette consumption has continued to rise during the past 20 years. In 1979, for example, an estimated 564 billion cigarettes were smoked in Europe — 186 billion more than in 1960, and 68 billion more than in 1970.

The reason seems to be that while fewer people are smokers, those who have not given up are compensating by smoking more. Average daily cigarette consumption in Europe was up to 14 in 1960, but has risen to up to 19 in 20 years.

The commission's statistics responded to a question from a Belgian member of the European Parliament who expressed concern at the continuing high toll of the smoking epidemic.

Indeed, the commission says several recent specialist reports confirm a long-term trend of increasing numbers of women in the ranks of young smokers.

A recent symposium here concluded, "lung cancer incidence in women, which used to be much lower than in men, now shows a constant rise — a consequence of their increased smoking habit."

(See — Lung — Page 2)

The community's council of ministers has put its faith in continuing health education and anti-smoking information campaigns. But insufficient funds are likely to prevent forceful, concerted action in the foreseeable future.

Cigarette consumption per head of population in Europe rose by an average of 23.2% in the decade to 1980. In Britain, the increase was as high as 49%. In Greece, the heaviest smokers registered a 40% increase. Even the Danes — who currently smoke less than any other nation in the region — increased cigarette consumption by 9.4%.

But in the past five years, overall tobacco consumption has at last levelled as smokers find themselves an increasingly unpopular minority in most social and business gatherings.

Ashtrays have accordingly disappeared from the boardrooms of many big European trans-national corporations, setting the tone of expectations of acceptable behavior in staff canteens and on shopfloors.

Nevertheless, Britain's Royal College of Physicians — perhaps the most powerful non-governmental source of influence on health policy within the European Community — has condemned official inaction in the face of what it describes as "a hidden holocaust" of death and disease caused by cigarettes (**The Journal**, Feb).

The first report on the subject published by the College in 1962 established the fatal link between smoking and cancer. Its second report, in 1971, identified other diseases associated with smoking.

Its recent fourth report has given a wealth of ammunition to an anti-smoking lobby comprising a coalition of consumer and health organizations here by demanding a ban on all sales promotion of tobacco, a steady annual increase in tobacco tax, and compulsory reductions in the tar, nicotine, and carbon monoxide yields of cigarettes.

Golobtsh

European smokers: more young people becoming addicted

'One-third of children are smoking'

UK aims anti-cig drive at teens

By Alan Massam

LONDON — The British government — bitterly criticized by health educators for being too soft on the tobacco industry — is at least showing concern about smoking among teenagers.

This was revealed by Parliamentary Secretary for Health John Patten at a "stop smoking" clinic at Dryden Road Hospital, Gateshead, County Durham.

He said recent research shows children under 16 are smoking £60 million (Cdn $108.5 million) worth of cigarettes annually, smoking causes an estimated 100,000 premature deaths each year in Britain, and smoking-related diseases cost the National Health Service £170 million a year. This is enough for 15,000 kidney transplants, or 20 major hospital building projects, he said.

"The government is concentrating on discouraging children from smoking," Mr Patten said, announcing publication of a leaflet to be sent to every school in the country.

The leaflet quotes research which says 37% of British 12-year-olds have experimented with smoking. By age 15 about one-third of children are smoking.

Mr Patten said other government initiatives to curb teenage smoking included a Health Education Council campaign using television and cinema advertising, and publication of guidelines for shopkeepers to prevent widespread abuse of the law forbidding them to sell cigarettes to children less than 16. Eighty-eight percent of children who smoke buy them from shops.

Mr Patten said he also thought a recent tax increase on cigarettes would discourage smoking. In fact, the Chancellor of the Exchequer increased tobacco duty by 10p (Cdn 18 cents) per pack of 20 cigarettes with corresponding increases for hand-rolled tobacco, and for cigarettes and cigars, although pipe tobacco was not affected.

Later, the National Society of Non-Smokers said the budget increase had merely restored the cost of tobacco in real terms to what it was in 1965, meaning tobacco duty had been kept below the inflation rate for 19 years. Yet when the tobacco tax increase was announced, one tobacco manufacturers representative was quoted as saying it was harsh and unfair.

"From every point of view except that of the tobacco trade, the decline in cigarette sales in Britain is a matter of rejoicing, not lamentation," a society spokesman said.

"The tobacco trade is still able to spend £100 million a year on cigarette promotion and publicity. Its determination to push the sales of cigarettes world wide in the face of all the known facts about the health risks is an incredible situation in a so-called civilized society."

NEWS

Any alcohol is incompatible with right to drive

By Harvey McConnell

ATLANTA — Establishing a rational social policy for alcohol use means more than focusing solely on drinking drivers, says the president of the American Council for Drug Education.

"I believe alcohol is the gateway drug to all intoxicating drug use in America and that teenage drinking is the central issue. It is time to get serious about the alcohol problem and to get serious about the problem of teenage drinking," said Robert DuPont.

Dr DuPont told the international conference of the PRIDE parents organization here the message being promoted is: "It's okay to drink, and okay to get drunk, but it is not okay to drive drunk; then the problem with drinking is the drunken driver."

Also controversial is the promotion of the disease concept of alcoholism and the assumption "there are two kinds of drinkers — one called social drinkers, like you and me, and another group called alcoholics; and they are somehow different and they have problems; and all we have to do is deal with the alcoholics, and we don't really have to think about social drinking."

On teenage drinking, Dr DuPont said there is a widespread feeling that it is okay in moderation and as long as it is not associated with drunken driving.

But the question raised is simple — what is safe?

"What constitutes 'safe' when we are talking about drunk drivers? Or drinking and driving? What constitutes safety when we are talking about social drinking? What constitutes safety when we are talking about teenage drinking?"

Dr DuPont said the greatest change occurring in substance abuse is the recognition that alcohol is a drug.

For example, there must be "zero tolerance" if the question of drinking on the highways, in the workplace, at school, and among teenagers is considered, he said. "It is inviting an epidemic if we accept any other standard.

"If we accept the concept that driving after drinking is okay, so long as one is not drunk, we are not only in violation of the evidence on the effects of alcohol on driving, we are not only in violation of the science on the effects of alcohol on driving, but we are actively promoting the very problem we are saying we want to stop."

The fight will be lost, as well, if it becomes acceptable for people to go to work, or teenagers to go to school, with alcohol or other drugs in their bodies.

On the highway, the standard must be "all drinking is a punishable offence, and it is incompatible with the right to drive a car."

Dr DuPont said society has the right to demand that employees go to work drug-free, and that teenagers go to school drug-free. The United States does not need to return prohibition "to bring a semblance of sense to our social policy about alcohol."

'Disease concept' of alcoholism still unproven, says Masserman

By Sissy Carpey

COATESVILLE, Penn — Jules H. Masserman, MD, who did seminal work on alcohol and stress interaction in animal experiments in the 1940s, has questioned the disease concept of alcoholism.

The term "disease" should be used only for physical incapacities, Dr Masserman said because, "no one has yet demonstrated any determinative genetic, constitutional, dietary, infectious, or other solely physiological causes of 'alcohlism.'

"Addiction to drink, then, can be called a 'disease' only in the sense that excessive eating, sleeping, smoking, gambling, vagrancy, or lechery may also be so classified."

Dr Masserman is professor emeritus of psychiatry and neurology, Northwestern University, Chicago, past president of the American Psychiatric Association, and life president of the World Association for Social Psychiatry. In 1946, he received the Lasker Award and, in 1974, the Sigmund Freud Award. He was keynote speaker here at the Veterans Administration conference on Stress: Alcohol and Drug Interactions.

Showing his pioneering film on the effect of alcohol on animals, which reported research begun in 1944, he said: "Human analogies hardly need elaboration. We are still inclined to take a 'bracer' before the presumed uncertainties of asking for a raise, proposing marriage, or demanding a divorce.

"Regrettably in many cultures including our own, intoxication is accepted to a considerable degree as a mitigating circumstance for the expression of erotic, aggressive, or destructive conduct that would be condemned in a completely sober person."

He said the physician's role is to treat the whole person, approaching the patient not as an "alcohol dependent, but as a complexly troubled human being seeking medical relief and social guidance.

"Addicts should not be encouraged to consider themselves helpless victims of some mysterious genetic or metabolic disease for which they cannot be held responsible . . . we must work to establish properly planned and staffed comprehensive health care facilities for preventing and treating the personal and cultural causes of drug addictions."

Vancouver anti-smoke law watered down by protest

WEST VANCOUVER, BC — Restaurant operators here have persuaded city council to butt out most of its anti-smoking by-law.

A proposal last October by Alderman David Finlay would have designated half of most public areas as smoke-free zones, with offenders liable to fines of up to $2,000.

But restaurant operators complained such restrictions would create financial hardship.

The council's revamped "clean indoor air and smoking regulation by-law" allows for three options. Restaurateurs can comply with the by-law's new standard of non-smoking in 25% of floor space, designate a smaller non-smoking area, or not have smoking restrictions at all.

Smoking policies must be posted at restaurant entrances, and in premises whose owners agree to comply with the by-law, customers would have the right to demand enforcement of the non-smoking rules. The fine for failure to comply has also been substantially watered down to a maximum of $500.

Lithium therapy toxic even at 'safe' doses

Sansone: hard to predict

BOSTON — University of Kansas neurologists have confirmed that high blood levels of lithium, used in the treatment of manic-depressive psychosis, can cause permanent neurologic damage, and poisoning of the nervous system can occur with "normal" blood levels.

Maria Sansone, assistant professor of neurology, told the annual meeting of the American Academy of Neurology here that it is difficult to predict which patients are most likely to suffer neurologic complications from lithium therapy, and the exact blood level at which problems may occur.

But evidence from a patient series suggests that strict dieting, a low-sodium intake, or the use of diuretic drugs, may predispose people on lithium therapy to neurotoxicity, she said.

"There is poor correlation between serum lithium levels and neurological status," Dr Sansone said. "The neurological picture can vary from an acute confusional state to a reversible dementia, to a permanent cerebellar syndrome with high levels."

Patients with high lithium blood levels should have immediate hemodialysis to minimize the risk of permanent brain damage, she continued. But even emergency blood cleansing measures do not guarantee that patients will not be left with irreversible neurological damage.

Dr Sansone illustrated this point with a case report of a young man who received two emergency hemodialyses and other measures to lower his dangerously high lithium blood level.

Although the emergency team restored his blood level to normal, the man had permanent speech impediments, tremors, and severe muscular incoordination.

Dr Sansone reported on three additional patients who developed neurotoxicity, even though blood levels were well within what is considered to be a safe and normal range. She said these patients are good examples of the very thin line separating therapeutic lithium levels from toxic levels.

Neurotoxicity in these patients manifested as extreme confusion, progressive but ultimately reversible dementia, and cerebrospinal fluid abnormalities that simulated infection and compounded the cognitive symptoms.

Liquor licence changes sought

Ontario beer lovers clamor for 'real ale'

By Jon Newton

TORONTO — Ontario New Democratic Party MPP Michael Cassidy has introduced a private member's bill calling for legislative changes which would allow brewpubs — premises selling ale made from natural ingredients — in the province.

Cassidy

Mr Cassidy, a staunch supporter of the 1,500-strong CAMRA (Campaign for Real Ale) Canada, told **The Journal**: "I lived in England for about six years and I thoroughly enjoyed the beer there. I'd like to see pubs making local beer in Ontario."

His amendment to the Liquor Licence Act would change the provision which bans absolutely any brewer from having licenced premises such as a pub, tavern, or lounge.

The proposal would create an exception for small brewers who produce less than 2,000 hectolitres annually, about 24,452 cases of beer, says Mr Cassidy.

"The aim of the bill is to permit the creation of small, independent pubs which brew and sell their own distinctive kind of beer as a friendly alternative to the mass-produced brands . . . from multi-million dollar corporations which now dominate the Ontario market."

Mr Cassidy will, in addition to his private member's bill, be submitting a comparable proposal to the Liquor Licence amendments currently before the legislature.

Real ale is brewed from natural ingredients like malt, hops, sugars, and other grains. Unlike "traditional" Canadian beer, which is chilled, carbonated, filtered, and pasteurized to prolong shelf life, real ale goes through none of these processes, meaning it keeps only for an average of 30 days after dispatch from the brewery.

CAMRA Canada, founded in 1981, is patterned on Great Britain's CAMRA, organized in 1972 to save Real Ale, the traditional draught beer in Britain (**The Journal**, Jan 1977).

Mr Charles MacLean, chairman of CAMRA Canada, says more than half of Britain's pubs now offer real ale and more than 100 new, small breweries have started up as a result.

Early in April, Mr MacLean told John Williams, parliamentary assistant to Ontario Consumer and Commercial Relations Minister Robert Elgie about the move to introduce locally made beers.

If Mr Cassidy's plea for changes to the Liquor Licence Act are approved, Mr MacLean expects about 40 brewpubs to be established here creating a "significant number of new jobs," boosting Ontario's tourist industry, and increasing provincial and federal tax revenues.

At the moment, British Columbia is the only province permitting brewpubs. Three such premises currently operate in BC, and a Manitoba entrepreneur recently spent $150,000 on a British-type mini-brewery for his Winnipeg hotel.

Mr Williams told **The Journal**, however, that he is not optimistic about quick action on Mr Cassidy's bill.

"Even if there is justification for it, I doubt whether it will be dealt with in this session of the House, if at all. It's going to take a number of months to sort out."

Mr Cassidy, however, remains undaunted.

"I don't think this will add to existing alcohol problems. What it will do is give consumers a wider choice, and add a bit of variety and diversity to beer. In any event, these kinds of pubs would be used mainly by connoisseurs and I don't think they're likely to create any further problems," he said.

"Also, small breweries — unlike the large companies — will not be able to promote or advertise heavily. As things are, companies like Molson and Labatt advertise every 12 minutes during some sporting events, and that probably does far more harm to children, say, than anything a microbrewery is going to come up with."

CAMRA: campaign started in UK

Licensing, patent protection under scrutiny

Task force investigates Cdn drug patent laws

By Jon Newton

OTTAWA — Federal Consumer and Corporate Affairs Minister Judy Erola has appointed an independent, one-man commission to examine ministry proposals that could lead to major changes in Canadian patent laws applying to generic and brand-name drugs.

"The commission will be focusing on the industry's expansion opportunities here in Canada," she says, "and will be assessing how it can contribute to the country's economic growth.

"Among policy areas to be reviewed, particular attention will be paid to the issue of patent protection and licensing as they affect this industry. The possible effects on drug prices of any policy changes will be an important consideration."

Harry Eastman, PhD, head of the $1 million commission, is an economics professor at the University of Toronto and former vice-president of research and planning at the university. He was president of the Canadian Economics Association and is a Fellow of the Royal Society of Canada.

Professor Eastman expects to report to the federal government by the end of the year.

"I'm right at the beginning," he told **The Journal**. "I'm the sole commissioner, but I will have a staff and will get some research done within the commission. There will be contracts let for research on clearly defined areas and objectives in the field of enquiry."

He said his area of expertise is, in part, industrial organization and its relationship to international trade; the general nature of the investigation, however, is not foreign to him, "although I'm not a specialist in this industry."

The federal government will seek discussions with the provinces on drug pricing, as well as establishing the Eastman commission.

As things exist, the Commissioner of Patents can grant automatic, compulsory licences for pharmaceutical companies to copy brand-name drugs and market generic preparations virtually as soon as the original drug goes on the market.

The principal criticism of the system by pharmaceutical firms which finance original drug research and development is that they end up passing the fruits of their labors to organizations marketing inexpensive "no-name" products (**The Journal**, June 1983).

Proposals which Professor Eastman will examine fall under three broad categories set out in a review, published last year, of Section 41 of the Patent Act. These include variable royalty rates, a period of market exclusivity, and company-specific exemptions.

A consumer and corporate affairs policy analyst explained to **The Journal**: "It's a balancing act between prices and industrial activity, and what's best for the Canadian economy.

"And the three approaches involve a delicate balance. Variable royalty rates mean, more or less, that if a company does a lot of research and investment in Canada, they get higher royalties when one of their products is subjected to compulsory licensing.

"The second option would offer a period of exclusivity for all companies. The pharmaceuticals themselves are asking for 10 or 12 years, which really equates with a 20-year patent, which is more than they have now.

On average, it takes about 11 years for generics to appear once the initial patentee's product is introduced.

"The third alternative would apply if companies met certain performance criteria."

Under the latter, exemptions could be granted to firms willing to provide industrial or economic performance plans with pricing assurances for their full line of products. Exemptions would be allowed for specific periods, after which past performance would be reviewed, future plans assessed, and the exemption renewed if performance was satisfactory.

The review document says pharmaceutical sales in Canada came to about $1.3 billion in 1981, representing under 2% of the free-world market for drugs. Virtually all of the Canadian market is held by multinationals; none is Canadian-owned.

Smoke mars rats' learning, memory

BALTIMORE — Chronic prenatal exposure to carbon monoxide has been shown to produce learning and neurological difficulties for rats, which may have implications for children of mothers who smoke during pregnancy.

Researchers at Johns Hopkins University here exposed pregnant rats to low concentrations of carbon monoxide throughout the term of pregnancy.

The experiment produced carboxyhemoglobin concentrations of about 15%, similar to those found in human smokers.

"While we cannot extrapolate the results to humans," comment the authors, in a report in *Science* (Jan 27, 1984), "they do resemble the often-cited impairment in achievement test scores noted during early childhood in the children of women who were heavy smokers during pregnancy."

Exposure to carbon monoxide produced only minor reductions in birth-weight and no obvious physical deformities in the baby rats, says the report. But evaluation of learning and memory processes suggests a functional deficit in the rats' central nervous systems.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. For further information, contact Margaret Sheppard at (416) 595-6150.

Youth Stress

Number: 606.
Subject heading: Attitudes and values
Details: 24 min, color.
Synopsis: Don Francks narrates this film about stress faced by today's youngsters, and how they respond to it. Interviews with stress expert Dr Hans Selye and youth workers cover positive and negative reactions to stress. Everyone has a choice when it comes to stress — either to give in to it and perhaps use drugs, alcohol, even commit suicide, or "go with the flow."
General evaluation: Poor to fair (2.5). This well-produced film seems to have conflicting messages: on the one hand an expert says stresses are greater on youth than ever before, while another expert says things today are no more stressful than in the past. The film does not suggest positive alternatives.
Recommended use: The assessment group believes it is important that a resource person be present to deal with any stress that may arise from viewing the film. Although intended for adolescent audiences, it could benefit parents and professionals working with youth.

A Fighting Chance

Number: 607.
Subject heading: Employee assistance programs (EAPs).
Details: 20 min, color, video. Also available in French.

Synopsis: Three people in different jobs have had personal problems that resulted in deteriorating work performance. Each recalls his or her problem, and how it was handled. EAPs are designed to help many employees who might otherwise be discharged because their personal problems have led to poor work performance. Ways supervisors and union people can handle such issues are discussed.

General evaluation: Fair to good (3.8). Although the message in this videotape was good, many members of the assessment group considered the pace of the film was slow and the narrator appeared to "talk down" to viewers.

Recommended use: In EAP promotion.

Drugs, Smoking, Alcohol and Pregnancy

Number: 608.
Subject heading: Drugs and pregnancy.
Details: 15 min, color.
Synopsis: A young couple is having a party with friends. The hostess is congratulated on her pregnancy. As she takes a cigarette, she is warned that smoking will hurt her baby: the fetus absorbs whatever the mother eats, drinks, and breathes. Pregnant women are advised to avoid all drugs, even cold medications.

General evaluation: Good (4.0). The assessment group liked the clear message in this film. General broadcast was recommended.

Recommended use: Would benefit pregnant women and those contemplating pregnancy.

NEWS AND DEPARTMENT

Fetal heartbeat reduction prompts moms to quit cigs

BIRMINGHAM — How do you get pregnant women to stop smoking — at least in late stages of pregnancy?

One way would be to let them listen to changes in their unborn babies' heart rates and movements after a few puffs, suggests a British obstetrician.

Writing in the *British Journal of Obstetrics and Gynaecology* (Feb 1984, 91, 111), J. Kelly, MD, of Birmingham Maternity Hospital, says he found decreases in the heart rates of fetuses and in fetal movement in 75 women who smoked. He found no such changes in 22 pregnant non-smokers. The women were examined between 35 and 39 weeks of pregnancy.

Smokers averaged a pack a day. Twenty-two had previously lost babies during pregnancy. Twenty-eight had growth retardation in the uterus in a previous pregnancy.

Smoking mothers were asked to stop for 18 hours and were then given either cigarettes without nicotine, or ordinary cigarettes. Those given ordinary cigarettes had significant increases in heart rates and arterial pressure while their unborn children showed decreases in movement and in heart rate. No changes were seen in women smoking nicotine-free cigarettes.

Dr Kelly concludes that the changes seen were primarily caused by nicotine, and says many women quit smoking once they had listened through a stethoscope to the changes that smoking produced in the children they were carrying.

DWI defence lucrative in DC

WASHINGTON — Lawyers here are reportedly rushing to defend drunk drivers and receiving hefty fees for their services.

Some even comb court records for drunk-driving arrests and send defendants letters suggesting they will face tougher sentencing if they fail to retain a lawyer, says a *Washington Post* survey.

It found many lawyers have increased their drunk-driving caseloads by up to 30% and have also doubled fees to $500 to represent first offenders.

New Books

by RON HALL

The Alcoholism Treatment Program at Canadian National Railways: A Case Study

. . . by Judith Groeneveld, Martin Shain, Donald Brayshaw, and Isabel Heideman

This report is intended to present a large body of data accumulated and analyzed in an effort to evaluate the Alcoholism Treatment Program at Canadian National Railways. As such, it is a compendium of research findings. The authors think that this report may have practical value to those engaged in Employee Assistance Program evaluation and to those who wish to see long-term data on a well-established industrial alcoholism program. Between 1972 and 1982, the program assisted more than 500 supervisors in their efforts to manage alcohol dependent staff more effectively. As a result, the costs generated by these employees were brought under greater control. The Alcoholism Treatment Program also provided an opportunity for more than 500 alcohol dependent employees to control their addictions and to build healthier and more productive lives for themselves. The authors conclude that although these are outstanding achievements, it should be recognized that the full potential of the program has not yet been realized. Recommendations for improvement are outlined.

(Addiction Research Foundation, Marketing Services, Dept JR, 33 Russell St, Toronto, ON M5S 2S1. 1984. 99 p. $7.50 ISBN 0-88868-092-9)

Narcotics and Reproduction: A Bibliography

. . . compiled by Ernest L. Abel

Arranged alphabetically by the author, this bibliography of 1,886 citations lists materials dealing with the effects of the use of heroin, morphine, methadone, and related narcotic drugs on human reproduction. Materials dealing with sexual behavior, sexual function, and sexual physiology have been included; however, the majority of the citations focus on the effects of narcotics on the fetus. The compiler has provided an introduction which traces the history of narcotic drugs, the incidence of their use among pregnant women, and the possible side effects of that use.

(Greenwood Press, 88 Post Rd W, Box 5007, Westport, CT 06881, 1983. 215 p. $29.95. ISBN 0-313-24052-3)

Adolescent Substance Abuse: A Guide to Prevention and Treatment

. . . edited by Richard Israelowitz and Mark Singer

The purpose of this work is to encourage exploration into the factors influencing chemical dependency among youth. The articles lend a new perspective to the field of adolescent substance abuse, or discuss topics which have received little attention in the literature. Adolescent substance abuse is discussed as a manifestation of social deviance. The physical and psychosocial factors which predispose children to addiction are presented. The importance of peer-group strategies for the prevention of drug abuse are reviewed. In an article on reducing drug use among black adolescents, the author focuses on the family as an underutilized drug prevention resource. Another article reviews the present state of knowledge with respect to substance abuse among Hispanic youth. The authors suggest that attention be paid to culture-specific programs, and delineate areas for future research, policy and programming. The prescribing of psychotropic drugs to the mentally retarded is the topic of another article. The final paper addresses programming strategies for the treatment of adolescent alcohol or drug abuse. Criteria are developed to distinguish the most appropriate level of care for the presenting clinical condition of the adolescent.

(Haworth Press, 28 East 22 St, New York, NY 10010, 1983. 123 p. $19.95. ISBN 0-86656-185-4)

Other books

The Drug User: Personality Issues, Factors, and Theories — Einstein, Stanley, Plenum Press, New York, 1983. Bibliography of 2,662 citations; personality theories and interventions; factors initiating treatment; treatment goals. 208 p. Plenum Press, 233 Spring St, New York, NY 10013. ISBN 0-306-40913-5.

Booze: A Script — Sallows, James R. Addiction Research Foundation, Toronto, 1983. A play comprising seven vignettes; director's copy with production notes and discussion questions. Script, 32 p. $2.50, ISBN 0-88868-086-4. Director's Copy, 71 p. $7, ISBN 0-88868-085-6. Package of 10 scripts and one director's copy, $20. Addiction Research Foundation, Marketing Services, 33 Russell St, Toronto, ON M5S 2S1.

Measurement in the Analysis and Treatment of Smoking Behavior — Grabowski, John and Bell, Catherine S. (eds). National Institute on Drug Abuse, Rockville, 1983. NIDA Research Monograph 48; smoking research issues; use of biologic fluid samples in assessing tobacco smoke consumption; measurement issues in cigarette smoking research; analysis of reinforcement by varying smoke component concentrations; physical indicators of actual tar and nicotine yields of cigarettes; smoking cessation in adults; evaluation of smoking risk; smoking prevention among children and adolescents. 121 p. US Government Printing Office, Washington, DC 20402.

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DEPARTMENT

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

10th Annual Conference Series on Death, Grief and Bereavement-Death and the Elderly — June 5-6, Toronto, Ontario. Information: Professional and Management Development, Humber College, 205 Humber College Blvd, Rexdale, ON M9W 5L7.

Policy Development to Manage Alcohol in Public Recreation Facilities — June 6, Sudbury, Ontario. Information: Joan Ruhnke or Reggie Caverson, Addiction Research Foundation, 144 Pine St, Ste 203, Sudbury, ON P3C 1X3.

Treatment of the Seriously Injured or Ill in the Emergency Room — June 6-8, Montreal, Quebec. Information: Carol Zaman, Postgraduate Board, The Montreal General Hospital, 1650 Cedar Ave, Montreal, Quebec H3G 1A4.

Lung Disease and the Primary Care Physician — June 8-9, Toronto, Ontario. Information: Continuing Medical Education, Faculty of Medicine, Room 114, FitzGerald Bldg, University of Toronto, Toronto, ON M5S 1A8.

Impact 84, The Citizen and the Criminal Justice System, an International Seminar — June 17-21, Toronto, Ontario. Information: R.E. Fox, Ste 214, 75 Lemonwood Dr, Islington, ON M9A 4L3.

Skills Update 84 — Developing Your Effectiveness as a Health Care Professional — June 21 or 22, Toronto, Ontario. Information: Jill Birch, Project Coordinator, Professional and Management Development, Humber College, 205 Humber College Blvd, Rexdale, ON M9W 5L7.

Canadian Pediatric Society Annual Meeting — June 23-27, Toronto, Ontario. Information: Canadian Pediatric Society — 410 Smyth Rd, Ottawa, ON K1H 8L1.

Canada Safety Council 16th Annual Safety Conference — June 24-27, Ottawa, Ontario. Information: Canada Safety Council, 1765 St Laurent Blvd, Ottawa, ON KG 3V4.

Medico-Legal Problems in Practice — July 9-14, Toronto, Ontario. Information: School of Continuing Studies, 158 St George St, Toronto, ON M5S 2V8.

9th International Congress of Dietetics — July 2-6, Toronto, Ontario. Information: Congress Canada, Ste 603, 250 University Ave, Toronto, ON M5H 3E5.

Management for Supervisors in the Health Care Setting — July 5-6, Aug 16-17, Toronto, Ontario, July 3-4, Edmonton, Alberta, Aug 13-14, Halifax, Nova Scotia. Information: Ingrid Norrish, Program Manager, Professional and Management Development, Humber College, Box 1900, Rexdale, Ontario M9W 5L7.

26th Annual Scientific Assembly of The College of Family Physicians of Canada — July 8-11, Vancouver, British Columbia. Information: The College of Family Physicians of Canada, 400 Leslie St, Willowdale, Ontario M2K 2R9.

Therapeutic Trends in the 80s — July 11-13, Montebello, Quebec. Information: Carol Zaman, Postgraduate Board, The Montreal General Hospital, 1650 Cedar Ave, Montreal, Quebec H3G 1A4.

25th Annual Institute on Addiction Studies — July 15-20, Hamilton, Ontario. Information: Karl N. Burden, Course Director, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

Summer Fundamental Concepts Course — July 16-19, 1984, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation (ARF), 8 May St, Toronto, ON M4W 2Y1.

Medical Women's International Association 60th Congress: Men and Women, Biological and Behavioral Differences — July 29-Aug 4, Vancouver, British Columbia. Information: Congress Secretariat, Medical Women's International Association, #1704-1200 Aberni St, Vancouver, BC V6E 1A6.

Canadian Society of Forensic Science 31st Annual Conference —Aug 18-24, Winnipeg, Manitoba. Information: Executive Secretary, Canadian Society of Forensic Science, 171 Nepean St, Ste 303, Ottawa, Ontario K2P 0B4.

1984 Annual Conference of the American Psychological Association — Aug 24-28, Toronto, Ontario. Information: American Psychological Association, 1200 17th St, NW, Washington, DC 20036.

University of Toronto Department of Psychiatry 10th Annual Research Day — Sept 21, Toronto, Ontario. Information: K. Drysdale, Secretary, Research Fund Committee, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Detox Training Programs (Non-Medical) — Sept 24-28, Oct 22-26, Nov 19-23, Toronto, Ontario. Information: Diane Hobbs, Coordinator of Detox and Rehabilitation Programs, ARF, 33 Russell St, Toronto, ON M5S 2S1.

Workplace 84 — "Making the Most of Human Potential" — An Employee Assistance Programming Conference — Oct 15-17, Grande Prairie, Alberta. Information: Iyas Abbas, Alberta Alcoholism and Drug Abuse Commission (AADAC), Provincial Bldg, Rm 2204, 10320 99 St, Grande Prairie, AB T8V 6J4.

5th Annual Meeting, Canadian Group Psychotherapy Association — Oct 17-20, Ottawa, Ontario. Information: Edgardo Perez, MD, department of Psychiatry, Civic Parkdale Clinic 3rd fl, Ottawa Civic Hospital, 737 Parkdale Ave, Ottawa, ON K1Y 4E9.

Event 84 — Skills Development Training Programs for Employee Assistance Personnel — Oct 28-Nov 1, Oakville, Ontario. Information: James Simon and Jaan Schaer, United Employee Assistance Councils of Ontario, Port Credit Post Office, Box 253, Mississauga, ON L5G 4L8.

Chemical Abuse and Your Employee — Nov 28, Jan 23, Toronto, Ontario. Information: Yvonne Johns, department head, Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-9, 1985, Calgary, Alberta. Information: Jan Skirrow, Chairman, 34th ICAA Congress, AADAC, 6th fl, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

United States

5th Annual National Conference on Employee Assistance Programming — June 4-7, Kansas City, Kansas. Information: Bethany Medical Center, The EAP Conference, 51 N 12th St, Kansas City, KS 66102.

10th Annual Colorado Summer School of Alcohol Studies — June 10-15, Aspen, Colorado. Information: The Alcoholism Council of Colorado, 2525 W Alameda, Ste 219, Denver, CO 80219.

Central States Institute of Addiction, Continuing Education Program on Addiction, 3rd Annual June Institute, June 11-15, Chicago, Illinois. Information: Stella Nicholson, or Mary Wannop-Catelain, Central States Institute of Addiction, 120 W Huron St, Chicago, IL 60610.

North American Conference on Alcohol and Highway Safety — June 12-14, Baltimore, Maryland. Information: Dr Patricia Santora, Program Director, Johns Hopkins University School of Medicine, 57 Turner Auditorium, 720 Rutland Ave, Baltimore, MD 21205.

Bio 84 Synthesis — June 16-21, Atlanta, Georgia. Information: Bio 84 Registrar, Rte 5 Box 311F, Midlothian, Virginia 23113.

Working with Parents — June 17-22, Minneapolis, Minnesota. Information: Community Intervention, Inc, 529 S 7th St, Minneapolis, MN 55415.

33rd Annual Session University of Utah School on Alcoholism and Other Drug Dependencies — June 17-22, Salt Lake City, Utah. Information: University of Utah School on Alcoholism and Other Drug Dependencies, PO Box 2604, Salt Lake City, UT 84110.

35th Annual Symposium on Alcoholism — June 18-29, Seattle, Washington. Information: Alcohol Studies Program, Seattle University, Seattle, WA 98122.

American Nurses Association: Challenges and Choices — June 22-28, New Orleans, Louisiana. Information: American Nurses Association, Inc, 2420 Pershing Rd, Kansas City, Missouri 64108.

2nd Congress of the International Society for Biomedical Research on Alcoholism — June 24-29, Santa Fe, New Mexico. Information: Richard A. Deitrich, department of Pharmacology, Alcohol Research Center, University of Colorado, Health Sciences Center, 4200 E 9th Ave, Denver, Colorado 80262.

Rutgers Summer School of Alcohol Studies — June 24-July 13, New Brunswick, New Jersey. Information: Summer School of Alcohol Studies, Rutgers University, New Brunswick, NJ 08903.

Chemical Dependency and Youth: Assessment and Intervention in the Schools — June 25-29, Livonia, Michigan. Information: Tom Berry, Fairlane Health Services Corp, 1 Parklane Blvd, Ste 1002 W, Dearborn, MI 48126.

13th Annual San Diego Summer Alcohol and Drug Studies Program — July 9-13, La Jolla, California. Information: Melanie Robertson, UCSD Extension, X-001, University of California, San Diego/La Jolla, CA 92093.

27th Annual Institute of Alcohol Studies — July 22, Austin, Texas. Information: Laura Burns, Texas Commission on Alcoholism, 1705 Guadalupe, Austin, TX 78701.

National Association of Alcoholism and Drug Abuse Counselor's Annual Conference — Aug 4-8, Indianapolis, Indiana. Information: NAADAC, 951 S George Mason Dr, Arlington, Virginia 22204.

The International Doctors in Alcoholics Anonymous Annual Meeting — Aug 9-12, Minneapolis, Minnesota. Information: Lewis Reed, MD, Information Secretary, IDAA, 1950 Volney Rd, Youngstown, Ohio 44511.

North American Congress on Employee Assistance Programs — Aug 12-15, Dearborn, Michigan. Information: Diane Vella, Congress Coordinator, NAC/EAP, 2145 Crooks Rd, Ste 103, Troy, MI 48084.

Alcohol and Drug Problems Association (ADPA) Northwestern Regional Conference — Oct 7-9, Seattle, Washington. Information: Eric Scharf, ADPA, 1101 15th St, NW, #204, Washington, DC 20005.

7th Annual School for Alcohol and Drug Studies — Aug 12-17, Wilmington, North Carolina. Information: North Carolina School for Alcohol and Drug Studies, Office of Special Programs, UNC-Wilmington, 601 S College Rd, Wilmington, NC 28403-3297.

16th Annual Nevada Substance Abuse School — Aug 20-24, Las Vegas, Nevada. Information: Angela L. Alaimo, Bureau of Alcohol and Drug Abuse, 505 E King St, 5th fl, Carson City, Nevada 89710.

Alcohol and Drug Problems Association (ADPA) 35th Annual Conference — Aug 19-23, Washington, DC. Information: Eric Scharf, ADPA, 1101 15th St, NW, #204, Washington, DC 20005.

American Association for Marriage and Family Therapy 42nd Annual Conference — Oct 18-21, San Francisco, California. Information: AAMFT Conference Committee, 1717 K St, NW, Ste 407, Washington, DC 20006.

18th Annual AABT Convention — Nov 1-4, Philadelphia, Pennsylvania. Information: John E. Martin, Program Chairperson, AABT/84, Psychology (116B), VA Medical Center, Jackson, Mississippi 39216.

4th Annual Fall Conference on Alcoholism — Nov 7-9, Williamsburg, Virginia. Information: Craig Nuckles, director, Riverside Hospital Alcoholism Treatment Program, J. Clyde Morris Blvd, Newport News, VA.

2nd National Conference on Alcohol and Drug Abuse Programming for Colleges and Universities — Nov 11-14, Boston, Massachusetts. Information: Eric Scharf, Alcohol and Drug Problems Association, 1101 15th St, NW, #204, Washington, DC 20005.

Abroad

III Congreso Iberoamericano sobre Alcoholismo — June 19-22, Cuenca, Ecuador. Information: Centro de Rehabilitacion de Alcoholicos, Casilla 331, Ecuador.

Families with Alcohol Problems: Models of Intervention — June 26-29, Dublin, Ireland. Information: Monica McGoldrick, Family Training Program, UMDNJ-RMS-CMHC, Piscataway, New Jersey 08854.

Helping Problem Drinkers to Help Themselves — the Aquarius/AARG experience — July 6, Birmingham, England. Information: Ms S. Raby, Aquarius, 41 Newhall St, Birmingham B3 3QD England.

3rd Biennial AU School of Justice Institute on Juvenile Justice —July 8-July 27, London, England. Information: Professor Richard A. Myren, Director, Institute on Juvenile Justice in England and America, School of Justice, The American University, Washington, DC 20016.

4th World Congress of Alternative Medicine — July 13-15, 1984, Amsterdam, the Netherlands. Information: Dr Anton Jayasuriya, Secretary, Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

International Narcotic Research Conference — July 22-27, Cambridge, England. Information: Linda Byford, Parke Davis Research Unit, Addenbrookes Hospital Site, Cambridge CB2 2QB UK.

3rd International Conference on Treatment of Addictive Behaviors — Aug 12-16, North Berwick, Edinburgh, Scotland. Information: William R. Miller, PhD, department of Psychology, University of New Mexico, Albuquerque, New Mexico 87131.

5th World Congress on Prevention — Aug 26-30, Rio de Janeiro, Brazil. Information: Ernest H. J. Steed, Executive Director, International Commission for the Prevention of Alcoholism and Drug Dependency, 6830 Laurel St, NW, Washington, DC 20012.

8th World Conference of Therapeutic Communities — NEW REVISED DATES — Sept 2-7, Rome, Italy. Information: Charles J. Devlin, Executive Director, Daytop Village Inc, 54 W 40th St, New York, NY 10018.

Seminar on Addiction — Sept 6-14, Athens, Greece. Information: Darcy Edwards, Millglen Medical Corp, PO Box 888673, Atlanta, Georgia 30356-0673.

International Congress on Alcohol Dependence, The Family and The Community — Sept 16-22, Jerusalem, Israel. Information: International Congress on Alcohol Dependence, the Family and the Community, Kenness International Inc, 1 Park Ave, New York, NY 10017.

11th International Conference of Social Gerontology — Oct 16-19, 1984, Rome, Italy. Information: International Center of Social Gerontology, 91, rue Jouffroy, 75017 Paris, France.

1984 World Congress of Acupuncture and Natural Medicines — Oct 19-24, Colombo, Sri Lanka. Information: Dr Anton Jayasuriya, Secretary, Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

2nd Inter-American Symposium on Health Education — Nov 4-9, Acapulco, Mexico. Information: Symposium Steering Committee, c/o NARO, PO Box 2305, Station "D", Ottawa, Ontario, K1P 5K0.

Prophylactics of Drug Abuse — Dec 10-12, Warsaw, Poland. Information: Secretariat of the Symposium, Society for Prevention of Drug Abuse, Aleje Ujazdowskie 22, 00-478 Warsaw, Poland.

12th International Conference on Health Education — Sept 1-6, 1985, Dublin, Ireland. Information: Dr H. D. Crawley, Director, Health Education Bureau, 34 Upper Mount St, Dublin, Ireland.

PUBLIC DEBATE AND COMMUNITY INITIATIVES*

Alcohol, health, and the democratic process

In May, at the Atlantic region meeting in Halifax of the Canadian Addictions Foundation, National Health and Welfare released a document entitled Alcohol in Canada: A National Perspective.

The document was prepared by an independent working group of scientists representing provincial commissions, federal government departments, and universities across Canada.

One of a series of statistical reports that has grown out of the Federal-Provincial Subcommittee on Alcohol and Other Drug Problems (see page 1), the publication addresses, to the field at large, the question of a national policy on alcohol.

In their introduction to the final chapter — Public Debate and Community Initiatives — the authors point out that while the data in the document are primarily national and provincial in scope and that the implications lend themselves to application at these levels, "it can hardly be overemphasized that the problems are originally and most intensively experienced in local communities.

"Therefore, the participation of the community in a healthy and full public debate is essential if initiatives are to have their full impact."

The chapter, reprinted below, deals with "some of the main considerations that communities may wish to take into account in developing effective responses to alcohol-related problems. In particular, it discusses selecting an appropriate perspective, creating community awareness, and taking action."

Selecting a Perspective

One of the first steps that a community must take in coming to grips with alcohol problems is to select an appropriate perspective for doing so. One perspective that can appeal to a wide variety of divergent and perhaps conflicting interests is the public health perspective.

Briefly stated, the public health perspective consists of the relationship of three elements — the host, the agent, and the environment. The host represents individuals who may be at risk of alcohol-related problems, the agent refers to the alcohol itself, and the environment refers to both physical and social factors external to the individual.

All of these elements must be considered in any comprehensive attempt to deal with alcohol-related or other kinds of health problems.

There are a number of key principles of the public health perspective that can help maintain productive public debate on alcohol issues.

For one, the perspective requires that the broad health concerns of the community would mean looking at alcohol problems in relation to other health and lifestyle issues of concern, such as smoking or nutrition. It would also mean studying the political, social, and economic forces that may help to produce alcohol problems.

Another principle of the public health perspective is that of controlling the hazards. In other words, intervention is only justified if there are genuine hazards that cause harm to individuals or communities. Each community will therefore have to decide if the hazards of alcohol are of sufficient magnitude to warrant intervention and, if so, which specific hazards are of particular concern.

A third principle is a focus on the group or community rather than on the individual. This helps to avoid the undesirable consequence of singling out particular individuals for community action and thereby "blaming the victim." The emphasis rather is on what can be done to change the social, physical, and attitudinal environment in which all members of the community live, so that certain groups of people are less likely to experience the hazardous effects of alcohol consumption.

A final principle is that of collective action. The public health perspective suggests that results can best be achieved by people working together rather than in an individual, uncoordinated manner.

Creating Community Awareness

Just as in the clinical management of individual cases, assessment of the problem is a critical factor in the denial, ownership, and eventual remediation of the community's alcohol-related problems. National and provincial data alone, as referenced in this report, will not serve singularly to motivate community response. Before the community can take action on these problems, it will have to assess its own experience with, and opportunities to respond to, the use and abuse of alcohol.

The first step then in any community response will be to validate its own experience and to verify whether the trends experienced elsewhere are also reflected locally and to what degree.

To accomplish this, it will be necessary to obtain information from key community informants and to analyze local statistical data on consumption patterns, drinking mores, Liquor Act offences, impaired driving charges, hospital separations, and specialized alcoholism treatment referrals and interventions.

From this will gradually emerge a recognizable pattern that will identify any convergence or divergence with provincial and national trends. This done, action can be taken to repeat the experience throughout the community and reinforce community awareness of the dimension and scope of its own problems.

An informed community can then initiate some inventory of its own resources and coordinate and strengthen its capacity to respond to and identify the most appropriate and potentially successful programs and strategies.

This second step can avoid duplication of effort and assist in learning from the evaluation of current and former responses to the problem. It will also serve to bring together some key community actors and to create a coalition of effort.

Finally, before a community proceeds headlong into action, it would do well to consider the limitations that face it. As is true of action at other levels, community action is constrained by the social policy context. Historical, ideological, political, and empirical constraints to policy development may also deter community action.

The community needs to be aware of these constraints and recognize that action without reference to context may be counterproductive or end in frustration unless attempts are also made to create a supportive social and policy milieu. In addition to community awareness of the dimensions of the problem, community attitudes towards alcohol will also have to be assessed.

While experience with alcohol may be unique to that community, it is clear that community attitudes are shaped by larger and more pervasive policies and mores in provincial and national jurisdictions. And since these policies influence community attitudes and may restrict community action, it is all the more necessary that local communities participate in the democratic process and formulate alcohol policy at a provincial and national level.

Taking Action

The factors noted below may have to be addressed either in concert or, depending on the local situation, in an order that differs from the one shown below.

1. A clear and detailed presentation of the issues and their relevance to personal and civic interests is central to effective action. In general, unilateral and sweeping approaches to problems — eg bans or prohibition, offering all alcoholics the same treatment — have been more clearly understood and debated than current proposals and initiatives on primary and secondary prevention. Single issue campaigns where the key components can be understood by many people have the potential for attracting the widest support. However, in the alcohol field (as well as elsewhere), the most effective action may need to touch on complex issues. An important agenda for the policy-makers, educators, and promoters at the community and other levels is that of presenting the key elements of an issue in a way that is relevant and interesting to the audience.

2. It is also particularly important that the leaders for the action are considered to have the credibility to speak or otherwise act on the issues. Depending on the locus of activity, official credentials may be of less importance than local respect and credibility. Credibility may not necessarily be tied to or limited to the specific issue; persons without particular expertise in the alcohol area may have a high degree of local and regional credibility. If they are not perceived as "experts," however, it is advisable for them to consult people who are considered locally to have expertise on the issue.

3. Identifying, linking up with, and forging alliances with people or groups having similar general goals are critical to a successful campaign. With respect to alcohol, alliances are feasible with church groups, institutions and associations concerned with health and diet, anti-smoking groups, traffic safety organizations, and associations promoting fitness. While independent, alcohol-specific efforts have the advantage of potentially greater control of both the focus and methods at the local level, such efforts may be in competition for a scarce supply of popular support. Joint efforts with natural allies might increase the chance of success.

4. Action also involves stimulating and maintaining interest and support. In addition to formal alliances with groups having comparable goals, informal campaigns at the one-to-one or small group level are particularly relevant to broadening the base of support. This may involve speaking to neighbors, friends, work associates, etc, as well as more formal initiatives otherwise known as lobbying. Through these actions, the issue under consideration can become a topic for informal discussion and can also make its way to the agenda of public debate, formal pronouncements, and activities by institutions.

However, there are both general and specific components for each of these: the sequence and coordination of activities to increase the potential for impact; methods and media used in presenting the issues and seeking support; handling criticism and opposition; retaining support and interest in the issue.

While it is beyond the scope of this chapter to make more than these basic suggestions, we believe that these important factors should at least be considered in both community and broader initiatives with regard to alcohol questions.

For further information and guidance on alcohol issues at the community level, readers may be particularly interested in the following two sources:

Guidelines for Investigating Alcohol Problems and Developing Appropriate Responses. Rootman, I. and Moser, J. Geneva: World Health Organization, Offset Publications, 1984.

Getting Active on Overdrinking: An Action Guide for Groups. Department of National Health and Welfare, Ottawa, 1983.

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The Journal

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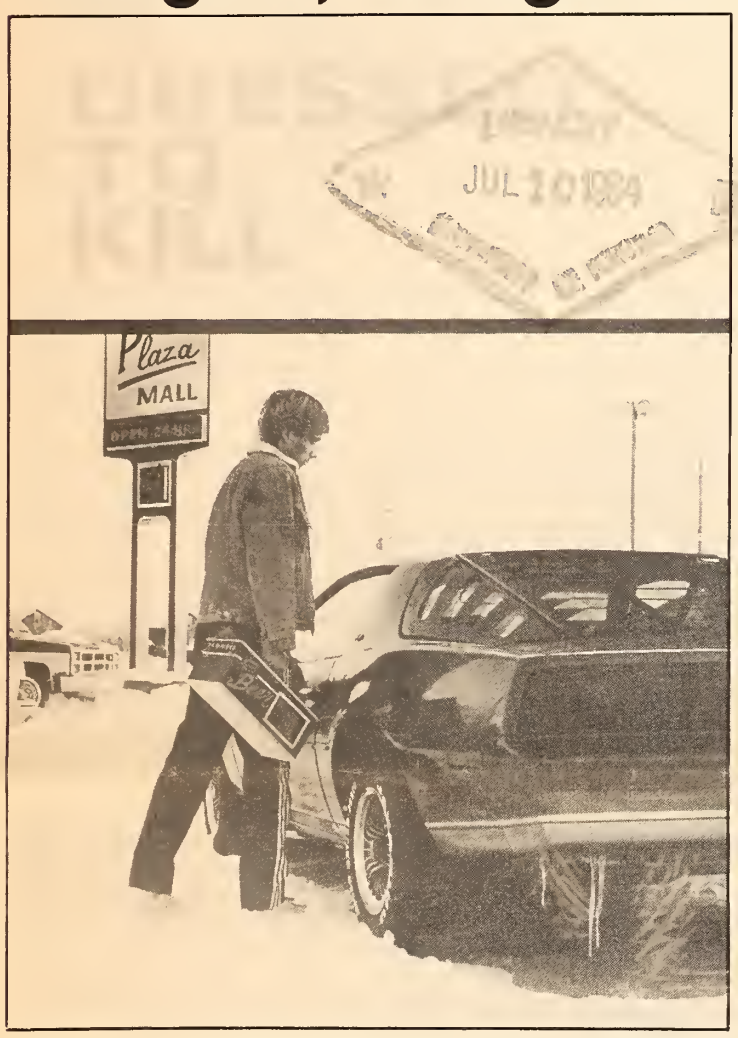
Reagan, Congress forcing drinking age hike

State road money in jeopardy



Warning: This poster message to teen drivers was one of nine winning entries from young people in a contest sponsored by the Addiction Research Foundation. Designer: Sherry Sandham, 19, Tillsonburg, Ont.

By Harvey McConnell

WASHINGTON — Pressure from United States Congress, with backing now from President Ronald Reagan, is going to force all of the states which have not done so to raise the minimum drinking age to 21 years.

It only remains for the United States Senate to follow the lower House of Representatives (Congress) and pass legislation which will deny federal highway funds — which pay for myriad projects — to any state which does not enact a minimum drinking age of 21 within two years.

The House approved its bill on a voice vote; raising the drinking age is now a bandwagon issue and seems impossible to stop in this election year.

At present, 22 states have a minimum drinking age of 21; nine have a 21-year minimum for spirits but allow beer and wine drinking by those younger; and the rest of the states have a minimum drinking age of 18, 19, or 20.

Federal highway aid, which is raised primarily from the federal gasoline tax, is apportioned to states on a formula basis. It is used on federal interstate highways within each state and for such other projects as rail and bus transit systems.

Such a move was recommended last December by the Presidential Commission on Drunk Driving. President Reagan said at that time that he was in favor of a minimum drinking age of 21 but opposed to federal legislation.

It is apparent many legislators believe advocating a minimum drinking age is a stand which will not lose votes in elections this November.

Others are like Representative James Howard, chairman of the House public works and transportation committee, who says he once thought such action should be left to the states without pressure from Washington. Now the statistics of teenage drinking and driving and accidents have caused him to change his mind.

According to the US National Highway Traffic Safety Administration, people aged 18 to 20 are more than twice as likely as any other group of drivers to be involved in an alcohol-related accident; and those aged 18 and 19 make up only 8% of the driver population but account for 17% of alcohol-involved drivers in accidents.

NZ doctors aiming for smoke-free year 2000

AUCKLAND — New Zealand can expect its first generation of non-smoking doctors by the year 2000, if the present trends continue.

This prediction is made by the medical director of the National Heart Foundation, David R. Hay, who says smoking rates among doctors halved in the 19-year period up to the 1981 general census.

"Both doctors and nurses have accepted their role as exemplars and made significant reductions in their level of smoking," he wrote in the *New Zealand Medical Journal* 1984; 97: 253-5.

From 1963 to 1981, Dr Hay said, the proportion of cigarette smokers among male doctors fell to 15% from 37% and in female doctors to 13% from 29%. Now, only 10% of all doctors less than age 24 smoke cigarettes.

Similar trends also occurred in nurses, with a reduction to 39% in men and to 31% in women. But smoking rates remain high among female psychiatric nurses (46%) and male general nurses (48%).

"Except for workers in religion, of whom 10% of men and 5% of women are smokers, doctors represent the lowest smoking occupational group in the community," Dr Hay said.

Drug fails as aid to cocaine addicts

By Harvey McConnell

ST LOUIS, MO — The tricylcic antidepressant desipramine is no more effective than placebo in helping cocaine addicts' withdrawal, a double blind trial by Forest Tennant, MD, and colleagues in Los Angeles has shown.

Dr Tennant told the annual scientific meeting here of the Committee on Problems of Drug Dependence the results mean that, at present, there are no studies which show an effective treatment agent for cocaine dependence withdrawal.

For the past three years or so, Dr Tennant, adjunct associate professor of epidemiology at the University of California at Los Angeles (UCLA) School of Public Health, and director of clinics in the Los Angeles area, said he and others speculated that the tricyclic antidepressants might help in the treatment of cocaine withdrawal. Studies *in vitro* indicated the tricyclics might block the re-uptake of norepinephrine into the neuron, or drive norepinephrine out of the neuron.

Dr Tennant said that the 22 patients selected for the trial were clients of a special cocaine dependence clinic at UCLA and had to meet strict criteria.

They had to have the perception they were addicted to cocaine; they had to have used cocaine several times per day for one month prior to admission (the average was eight to nine times per day); they could not have any other dependency, including to alcohol or other drugs; and they had to have cocaine present in the blood plasma or urine.

The patients, including five women, had an average age of 28 years; average overall cocaine use of from 50 to 65 months; and mean average daily use of 1.5 grams.

Tennant: no better than placebo

Cocaine was found in all urine samples.

"One of the things we learned in this study is that cocaine dependent subjects tend to seek treatment when they are ill, which means they have stopped cocaine use in the previous 24 to 48 hours."

The study lasted six weeks. For the first five days, clients were seen daily and then twice a week for the rest of the period. They were given either 25 milligrams desipramine or placebo tablets. Maximum dosage was 100 mg the first day and clients were told they could raise it to 150 mg per day according to their symptoms.

Dr Tennant said each time the patients attended the clinic they were asked a battery of questions, including whether the drugs they were taking reduced the cocaine craving, whether they had more energy, whether depression had been prevented, and whether they were sleeping unassisted. They were also asked about withdrawal symptoms.

He said about 60% of patients in both the desipramine group and the placebo group said there was a reduction in craving for cocaine. About half of each group said the drugs prevented depression, and significantly more people in the placebo group said they slept better.

He added that the study "indicates there was no difference between the two groups, and we have to conclude that desipramine is no more effective than placebo in withdrawing people from cocaine dependency."

Desipramine is manufactured under the brand names of Norpramin and Pertofrane.

Concern about PPA may obscure the larger problems of look-alike drugs.

p2

INSIDE

NEWS

Focus on PPA leaves larger problem neglected

By Jon Newton

NEW YORK, NY — Banning the drug phenylpropanolamine (PPA), which is widely used in over-the-counter (OTC) cold medicines and diet pills in the United States, and implicated in the look-alike drug scene here, would have no impact on the overall abuse problem.

Rather, such a move could divert energy from more constructive approaches, believes David Smith, MD, founder and medical director of San Francisco's Haight Ashbury Free Medical Clinic.

His view was shared by the majority at the first conference on PPA at the New York Academy of Medicine here last month.

Organizations like the powerful US Center for Science in the Public Interest have called for a total ban of PPA in the US "to protect the consumer."

However, the body of opinion at the end of the two-day symposium held that PPA should be considered in an abuse context only when it's used with such ingredients as caffeine and/or ephedrine which, until a change in US legislation last year (**The Journal**, February), were commonly combined with PPA. (In 1983 the US Food and Drug Administration ruled that PPA cannot be sold in combination with either caffeine or ephedrine. Previously, it had been available in double or triple combinations including either caffeine or ephedrine, or both.)

Far more deserving of attention are look-alikes in general, particularly those made to resemble hypnotic sedatives or cocaine, delegates agreed. Also important are drugs of deception — preparations resembling controlled drugs and which may contain controlled ingredients, but which are in fact counterfeits with their own potential for abuse, and with possibly lethal side-effects.

The look-alike drug problem became a serious issue in the US after reports of heavy abuse, especially by youngsters, and PPA was singled out as probably the most dangerous ingredient.

The situation was further exacerbated by clinical reports of patients apparently suffering cardiovascular and neurological complications after taking diet pills and other preparations containing PPA. (See — PPA-caffeine — Page 4)

Canadian diet aids do not contain PPA, but it remains an ingredient in many cough and cold medications.

Look-alikes are preparations — usually pills or capsules — purporting to mimic the "upper" or "downer" effects of controlled substances like amphetamines and barbiturates. They are not legally available in Canada, but are nonetheless around, as evidenced by experiences of workers at the Addiction Research Foundation of Ontario (ARF) who recently reported that look-alikes now account for more than half the drugs brought in for analysis.

Last year, of 174 samples brought in to the ARF for identification, 92 turned out to be look-alikes, says Eva Janecek, acting head of pharmacy.

John Morgan, MD, director of the pharmacology program in the City College of New York's biomedical school, and principal conference organizer, pointed out that PPA has been freely available since the 1930s and has been primarily used in OTC cough and cold products, and more recently in diet aids.

Many over-the-counter preparations contain PPA

"Its use expanded markedly in the late 1970s as retail sales of appetite suppressant products using PPA increased dramatically, with sales last year exceeding $200 million," he said.

"There has been an enormous increase in exposure and availability — the look-alike explosion, diet pills, and OTC preparations containing PPA."

But, says Dr Smith, PPA is not the villain of the piece and continues to have a value in OTC preparations. Many problems associated with it stem from advertisements in drug culture publications for look-alike substances.

"There is no evidence that PPA will produce the effects desired and advertised," he states. "In this context, we need to expand our efforts in terms of the prevention of look-alike pleasure-seeking behavior. We need to expand our efforts in family education, we need to expand regulatory efforts aimed at the type of promotion and advertising mentioned.

"But none of this would be impacted by the banning of PPA, which I believe happens to be one benign ingredient in the overall look-alike drug abuse phenomenon.

"In fact, looking at our experience and some of the opinions presented at this conference, you could make a better case for banning caffeine."

More next month on PPA: its risks and benefits.

Briefly...

Weed inspectors

CLARKSDALE, Miss — The problems of finding summer employment in Coahoma County here may have been solved. The County Sheriff's department is looking for extra help seeking out marijuana patches in this fertile land near the Mississippi River. They'll pay $25 for directions to a marijuana patch of from 25 to 49 plants and double that for larger patches, says a report by *Associated Press*. Tips must be given in person, with adequate directions, and will be kept confidential, officials say.

A helping hand

ORLANDO, Fla — A street-side survey by two journalism students here found that many people are willing to help an intoxicated person get behind the wheel to drive home. The students, pretending to be intoxicated, stopped pedestrians on a busy street saying they were too drunk to unlock their car doors. Fifty people were stopped, 21 offered assistance.

Wine makers worried

NIAGARA — Ontario wine growers are concerned they'll run out of space to ferment this year's crop as sales continue to slump and much of last year's bumper crop remains in fermenting tanks. The Wine Council of Ontario says removal of a 65 cents a bottle handling charge on imported wines is chiefly responsible. They say that resulted in a drop in domestic wine sales, particularly of Ontario's newer and better wines. They fear a task force investigating the problem won't deal quickly enough to help them this year.

Hidden smoke costs

DALLAS — Covering the hidden costs of smoking would add $3 to the price of each package of cigarettes, a United States medical economist told the annual meeting here of the American College of Cardiology. In a report in *The Medical Post*, Gerry Oster, PhD, said that in terms of lost productivity and health care, a male two-pack-a-day smoker between 40 and 44 years incurs costs of more than $46,000. For a male pack-a-day smoker the costs would be $33,000. For women in the same age groups costs would be $19,400 and $9,000 respectively.

Seven BC doctors face drug probe

By Tim Padmore

VANCOUVER — One of seven doctors charged here with trafficking in addictive drugs is a director of the British Columbia Medical Association (BCMA) and chairman of the association's drug dependency committee.

Kenneth Varnam and six other physicians were charged in May after a police undercover operation that began in November 1983 and ended in January.

Separate trial dates for the seven doctors charged — Dr Varnam and Drs Robert Schulze, Anthony Read, Anthony Otto, Gabriel Yong, Charles Chow Tai and Carlos Guzman — have been set between August and the end of October.

Drs Varnam, Otto, Read, and Schulze are also charged with being practitioners unlawfully administering a controlled drug.

Police have said the investigation was prompted by increased amounts on the street of prescription drugs like Ritalin (methylphenidate hydrochloride), Talwin (pentazocine), and Valium (diazepam).

Police have submitted a report on five more doctors, who were not


Varnam

charged, to the College of Physicians and Surgeons of BC.

A College spokesman told **The Journal** the College has not been party to the investigation, but may institute its own inquiries if the report provides concrete information.

At least one of the doctors (Dr Varnam) has a licence from the Bureau of Dangerous Drugs to prescribe methadone for the treatment of narcotic addiction. A Bureau spokesman in Vancouver told **The Journal** that while the Bureau is monitoring the situation, no action has been taken with respect to any of the doctors.

Dr Varnam, who has been active in the BCMA for many years, has indicated he does not plan to resign his BCMA posts.

At this year's annual general assembly of the BCMA, held the first week in June, the drug dependency committee that Dr Varnam heads made several recommendations to combat drug abuse:

- computer links among all BC pharmacies so that prescription orders can instantly be checked against records in other pharmacies;
- government-run or -funded clinics to treat all drug dependent people in a "humane, medically-oriented" atmosphere;
- cooperation between government agencies and private physicians; and,
- physician support — including donations of money — to the Alcohol and Drug Education Service, which runs school programs on drug abuse.

All the resolutions were approved by the assembly.

US groups are teaming up to warn kids of pot risks

By Harvey McConnell

MIAMI — Don't let your lungs go to pot," is the theme of a joint public health program aimed at nine- to 11-year-old youths and drawn up by the American Lung Association and the American Council for Drug Education (ACDE) in the United States.

The program includes public service announcements and posters featuring the cast of the US television series, Fame, news magazines, and guides for parents and teachers.

At the conference unveiling the program, Donald Tashkin, MD, professor of medicine, University of California at Los Angeles, reported further findings among the 200 young adults taking part in an ongoing study, who have smoked one or two marijuana cigarettes a day for the past five years.

Dr Tashkin said that squamous metaplasia, which often precedes cancer, was found in 24 of 25 marijuana smokers who allowed doctors to take lung biopsies. The others in the study had lung capacity measured and showed narrowed airways, abnormal cells, respiratory congestion, and chronic bronchitis.

Lee Dogoloff, executive director of the ACDE, noted that "a significant percentage of the American public still believes marijuana is harmless," and the aim must be to teach children before they start experimenting with marijuana.

"Since nearly every child in this country between the ages of 12 and 14 will be faced with the decision of whether or not to smoke marijuana, it is imperative that consistent prevention messages reach them before that time."

When children are given factual information, they are better able to resist peer pressure and to make better decisions against the use of all drugs, including marijuana, he added.

The program, called Marijuana: A Second Look, has US First Lady Nancy Reagan as honorary chairman.

Officials pointed out that the American Lung Association has not taken a position on the moral, ethical, or legal issues involving marijuana. Its purpose is to motivate children of the US not to smoke marijuana because it seriously affects the health of the lungs.

Three-quarters of seniors have jobs

Working teens outdrinking their peers

By Harvey McConnell

CHEVY CHASE, MD — High school students who have part-time jobs drink more than their peers who do not work, suggest data presented at the National Conference for Youth on Drinking and Driving.

Overall, some 75% of United States high school seniors hold jobs, mostly at fast-food outlets or neighborhood stores where local young people meet to socialize.

Among teenagers who work more than 21 hours a week, 48% said they were involved in heavy drinking episodes — defined as five or more drinks during a single period — at least once during a two-week period. Thirty-three percent experienced episodes of heavy drinking at least twice during the same period.

Teenagers who work spend the second largest amount of time away from home at the place where they work, says the survey, which was done for the institute by the researchers at the University of Michigan who also do the annual survey on high school senior drug use for the US National Institute on Drug Abuse.

In a speech prepared for the conference, Secretary of Health and Human Services Margaret Heckler (who was unable to attend at the last minute) said there are many signs that American attitudes to alcohol are changing "and, fortunately, the American people are showing an increased concern about alcohol-related problems."

Releasing at the same time the fifth special report on alcohol and health, Secretary Heckler noted that it "shows the devastating toll that alcoholism and alcohol abuse are taking on Americans."

Among findings in the report:

- The death rate from fire is 10 times greater among alcoholics than non-alcoholics, and the suicide rate of alcoholics is from six to 15 times greater than that of the general population.
- Drivers with blood alcohol levels above 0.10% are three to 15 times more likely to have a fatal accident than non-drinkers. Pedestrians with blood alcohol levels about 0.10% are twice as likely to be hit by a motor vehicle.
- A study of accidental deaths in the workplace found 11% of those who died had blood alcohol levels above 0.08%, a high level of alcohol use not typical of workers generally.
- Drinking is estimated to be involved from 45% to 68% of spouse abuse, and as high as 38% of child abuse.

Heckler: devastating toll

Common-law wives at high risk for alcoholism

By Heather Walker

SEATTLE — Women who live with men to whom they are not married, women who work part-time, and those who are temporary abstainers have been identified as new high risk groups for alcohol abuse in an epidemiological study.

Sharon Wilsnack, associate professor of behavioral science at the University of North Dakota School of Medicine, Grand Forks, reported on her findings here at the National Research Conference on Women and Alcohol.

"The difference between cohabiting women and other groups is quite striking. It may be a non-conventionality factor — these women may just be less conventional people — or there may be some stress connected with that status," said Dr Wilsnack.

In Dr Wilsnack's data on 917 women, all of the "cohabiting" women were drinkers — 49% were light drinkers, 32% drank moderately, and 18% were heavy drinkers. Of the other groups, only 5% of married women, 7% of divorced and separated women, 1% of widows, and 9% of women who had never married drank heavily.

Dr Wilsnack said the temporary abstainers in her survey may have abstained as a reaction to alcohol problems.

"These temporary abstainers reported drinking problems and alcohol dependence symptoms more often than other categories of light drinkers," she said. "This pattern suggests that some drinkers who notice drinking-related problems may try to deal with these problems by abstaining from alcohol for a period of time."

Focus: on women drinkers

Dr Wilsnack's survey also showed that, although there has been increased focus on drinking by women, there has not actually been a great increase in women's drinking in the past 10 years.

"It is difficult to reconcile the growing public concern about women's drinking with the lack of evidence that women's drinking has suddenly and drastically increased," she said.

The concerns may have come from efforts of women's advocates to increase awareness of different problems faced by women and men drinkers. Or, she added, "attributing increased alcohol problems to contemporary women, like attributing increased rates of stress-related disorders to women, may reflect current social discomfort about possible consequences and costs of women's liberation from traditional sex roles."

Dr Wilsnack's study showed a clear connection between women's drinking patterns and those of husbands, friends, and close relations.

"The data showed that women are likely to drink in the way that their husbands or partners drink," she said. "If husbands or partners were non-drinkers, 79% of the wives abstained. If husbands drank occasionally, 56% of the wives drank lightly, and if husbands drank frequently, 56% of the wives drank at moderate or heavier levels."

Wilsnack: no drastic increase

Dr Wilsnack says her survey identifies high-risk groups that need more study to determine appropriate treatment and prevention measures.

However, she says more work is also needed to determine whether some of the patterns she's found are the cause or the result of women's drinking.

"For example, which comes first, the divorce or the drinking? We need longitudinal studies to learn that. Again, we found a strong relationship between women's drinking patterns and those of partners and friends, but did drinking by these people influence the women, or did they find partners with patterns similar to their own?

"The same is true with women who work part-time and drink more heavily than those who work full-time. Do they drink because of something connected with their part-time work, or are they unable to find full-time work because they drink?"

Dr Wilsnack hopes to conduct a longitudinal follow-up study of her sample of 917 women in 1988 or 1989 to answer some of these questions.

Coming up in

The Journal

- **PPA: its risks and benefits**
- **More from the Committee on Problems of Drug Dependence**

Tippling managers gaining competitive edge?

By Wayne Howell

A decade or so ago, MBO was a popular buzz-word among MBAs. In other words, people with Master of Business Administration degrees were all agog about the possibilities of "Management By Objective."

No one knew better how to apply MBO than the Japanese, assuming their objective was to corner the market in high-quality consumer electronic products and state-of-the art automobiles. Those objectives met, the Japanese set another: to meet and surpass American micro-chip technology. In 1976 the Japanese government launched the VLSI (Very Large Scale Integrated) semiconductor project, a four-year, $300 million project that brought together five large electronics manfacturers in a research and development association. The unusual, cooperative project was a spectacular success, to the point that the Japanese have now seized world leadership of the $4 billion market for mass-produced computer memories. Another triumph for MBO? Well, not exactly. According to a recent article in *The Financial Times*, Kiyonori Sakakibara, a visiting scholar at the Massachusetts Institute of Technology's (MIT) management school, attributes VLSI's success to MBW — not MBO.

The Financial Times describes MBW as a 'delightfully unorthodox' management technique. In fact, it is nothing new in corporate and bureaucratic circles; it has been around for centuries in one form or another. But it took Professor Sakakibara to give it a name, and the organizational genius of Japanese industry to bring it to fruition as a management tool.

According to Prof Sakakibara, it was Masata Nebashi, the VLSI's managing director, who utilized MBW principles to meld the suspicious, egocentric, antagonistic scientists from the five competitive corporations into a formidable research team. How did he do it?

"All I did for these four years," Mr Nebashi explained, "was to drink with them as frequently as I could." Here we have the essence of MBW, or "Management By Whisky," to use the term coined by the MIT business school academics. And here we have the results of MBW, as reported in *The Financial Times*: "Gradually, an *esprit de corps* developed as members of the team met night after night to fill their glasses and empty their souls. By the end of the project, many had become firm friends, and an alumnus association was formed, with its own newspaper."

Filling glasses and emptying souls. This is, to say the least, journalistic excess, almost on a par with *The Globe and Mail*'s provocative reprint headline, Japanese Microchip Feat Partly Achieved by Drinking.

To get the proper management-science perspective, one has to turn to Prof Sakakibara: "The cooperative laboratory, which was an organization at first, became an institution by the leadership of Mr Nebashi. He embodied the association's values; he infused it into the hearts of the researchers; he gave it the distinctive character; he lent it a social integration that went well beyond formal coordination and command."

It is hard to imagine a more clear and concise exposition of how Mr Nebashi utilized MBW to achieve his management objective. And, if Mr Nebashi were presented with the cavil that Prof Sakakibara's explanation is neither clear nor concise because the pronoun "it" seems to have a multitude of reference points, I am sure that his response would be soundly based in the theory of MBW. I can hear the father of modern MBW science saying: "I tell you what; let's split a quart of Johnny Walker Red Label and see if it still matters to you."

Given the success of the VLSI project under Mr Nebashi, it would appear that the future of MBW is bright and glorious. But despite that success, *The Financial Times* strikes a cautionary note: "The question that Prof Sakakibara's paper begs — but does not really answer — is whether the magic formula can be transplanted to other joint R and D (Research and Development) projects, both in Japan and elsewhere."

Personally, I think that given a manager as dedicated as Mr Nebashi, a manager who is willing to lay his liver on the line for a four-year stretch, and given a properly organized EAP (employee assistance program) to deal with those recalcitrant employees who insist on imbibing mineral water with lemon, the "magic" could happen just about anywhere. In any event, the next time you see a group of WASP MBAs olive-deep in a three-martini lunch, tip your hat and give them the thumbs-up sign; they're not just becoming firm friends and planning their own newspaper — they're our own MBW shock-troops fighting to save what few domestic industries we have left from the Japanese industrial juggernaut.

NEWS

RESEARCH UPDATE

Young professionals on drugs

Boston research describes the cases of six, drug-addicted health professionals whose dependence stemmed from early recreational drug use rather than from self-treatment or easy access to drugs, which are viewed as traditional occupational hazards for health workers. William E. McAuliffe, department of behavioral sciences, Harvard University School of Public Health, says today's young professionals have grown up in an era marked by tolerance of drugs and that his subjects "may soon represent an important societal problem." He studied the drug use histories of a medical doctor, a nurse, two pharmacists, and a nursing and a pharmacy student nontherapeutically addicted to drugs including marijuana, cocaine, and opiates. All "responded rather well to drug treatment, more comparable to other addicted health professionals than to nontherapeutic street addicts." He advises, however, that because such professionals have access to black market as well as therapeutic drugs and are motivated by drug-oriented lifestyles, "longer, inpatient treatment and self-help approaches aimed at changing values and lifestyles may be a suitable, alternative rehabilitation model" to the traditional model for addicted physicians.
American Journal of Drug and Alcohol Abuse, 1984 v.10:1-22

Smoking inhibits chest pain drugs

Cigarette smoking lessens the effectiveness of drugs used in control of angina (chest pain). That is the finding of a group of British researchers from the division of cardiology, Hammersmith Hospital and the National Heart Hospital, London. Ten typical angina pectoris patients, who had been smoking for at least 10 years, underwent one-week treatments while smoking and not smoking. The four treatments were placebo, nifedipine (a calcium antagonist), propanolol (a nonselective beta blocker), and atenolol (a selective beta blocker), in standard maximal clinical doses. A record of chest pain was kept, and patients underwent an exercise test before the study and after each treatment period. The study found the frequency of angina episodes and resting and exercise-induced heart rate fell when patients stopped smoking; stopping smoking also significantly increased the effect of the drugs, most markedly nifedipine, on heart rate and angina frequency.
New England Journal of Medicine, April 12, 1984, v.310:951-954

Lab test for depressed alcoholics

Identification of major depressive illness in alcoholics is critical but difficult in the absence of laboratory tests to back up symptoms-based diagnoses, particularly when alcoholics are self-medicating the depression with alcohol or prefer a diagnosis of alcoholism to one of depression. Now, six physicians at Fair Oaks Hospital, Summit, NJ, and the Falkirk Hospital, Central Valley, NY, suggest one of two neuro-endocrine tests "widely recognized as laboratory aids" in depression diagnosis, also has potential as a test for depression in alcoholics. This is despite their early concern that endocrine abnormalities associated with alcohol abuse might reduce efficacy of the test. The team examined dexamethasone suppression test (DST) and thyrotropin-releasing hormone (TRH) in 32 chronic alcoholics without depression, liver disease, or withdrawal syndrome. Fifteen patients who suffered withdrawal in the first week of admission received both tests, as did all 32 patients in week four, in addition to 20 normal controls. Significant abnormalities would suggest the tests lacked sufficient specificity, the doctors say. Abnormalities were seen with TRH tests. However, although DST abnormalities were seen in three patients in acute withdrawal, normal results were seen in all alcoholics tested in week four of sobriety. Although further research is needed to test the results, says the team, "the DST would appear to have excellent potential as a specific laboratory adjunct in the diagnosis of depression in alcoholics." The researchers suggest clinicians use the test "after the resolution of alcohol withdrawal and perhaps only after three weeks of sobriety."
American Journal of Psychiatry, May 1984, v.141:680-683

Smoking cessation and weight gain

A possible method has been found for identifying which smokers will gain weight when they quit. It is based on the finding that activity in adipose-tissue lipoprotein lipase (a key enzyme in the uptake and storage of fatty tissue) is higher in smokers prone to putting on weight when they stop smoking. The discovery was made by Robert Carney, PhD, and Andrew Goldberg, MD, of the departments of psychiatry, preventive medicine, and medicine and the Lipid Research Center, Washington University School of Medicine, and the Jewish Hospital of St Louis, St Louis, Missouri. They measured lipoprotein lipase activity in 18 smokers before they stopped smoking, and in 12 controls. Subjects were weighed two and three weeks after smoking cessation. The amount of weight gained was greatest in those with the highest baseline levels of lipoprotein lipase activity in adipose tissue, measured in tissue obtained from the buttocks. This gain was not related significantly to subjects' body weight, fat-cell size, or the number of cigarettes smoked. Although the mechanism responsible for the relationship is not known, the researchers concluded that people "with elevated levels of enzyme experience a rapid increase in body weight when the weight-reducing influences of cigarette smoking are stopped." They said the measure of this enzyme "may be useful clinically in predicting a smoker's potential for weight gain upon quitting smoking."
New England Journal of Medicine, March 8, 1984, v.310: 614-616

Pat Rich

PPA-caffeine diet pill combo 'hazardous' in hypertension

BOSTON — Over-the-counter diet pills sold in the United States and containing phenylpropanolamine (PPA) and caffeine may be just as dangerous as street drugs known as look-alikes — preparations with the same ingredients.

(Although diet aids in Canada do not contain PPA, the drug is an ingredient in many cough and cold remedies.)

Drug store versions generally contain lower dosages of active ingredients than street counterparts, but they are capable of producing serious neurological complications like those already reported in the medical literature on the hazards of look-alikes, says Shirley Mueller.

A neurologist and physiologist at the Indiana University school of medicine, Indianapolis, Dr Mueller told the annual meeting of the American Academy of Neurology here that many unexplained neurological symptoms may be caused by non-prescription diet pills.

"Four of our five patients (with neurological complications) took more than the recommended dose of diet preparations per day," Dr Mueller said.

"It is well known that over-the-counter drugs are commonly taken in greater than recommended dosages because the public thinks they are safe. But even when the recommended dose is taken, individual variability could lead to complications in one individual and not in others."

The five patients seen by Dr Mueller were taking Dexatrim, a popular non-prescription diet pill in the US. Acute neurological symptoms ranged from irritability, restlessness, and insomnia while taking only one Dexatrim per day, to seizures following the ingestion of 17 Dexatrims in one case. (In Canada, Dexatrim contains methylcellulose and benzocaine instead of PPA and caffeine.)

Chronic symptoms from long-term use included nervousness, nausea, and headache.

Neurologic signs included dilated pupils, hyperactive reflexes, and uncontrollable muscle jerks. Blood pressure was raised in the four people who took more than one capsule daily, but all neurological signs and symptoms and elevated blood pressure resolved when the diet drugs were discontinued, Dr Mueller said.

"Both phenylpropanolamine and caffeine cause central nervous system stimulation and increased blood pressure," she said. "Thus, in combination, the effect of one could be potentiated by the other."

Dr Mueller warned the use of such drugs may be especially hazardous in people with a history of high blood pressure, those with borderline hypertension, and those with a family history of hypertension.

"In animal studies, existing hypertension has been demonstrated to increase dramatically cerebrovascular complications when phenylpropanolamine and caffeine were administered," she said.

"Recognition of the association between diet preparation complications and a predisposition to an elevated blood pressure is important because hypertension is more common among overweight individuals who tend to take diet pills."

Druggists 'have a responsibility'

Campaign aims to ban tobacco

By Bruce Constantineau

VANCOUVER — The Canadian Pharmaceutical Association (CPhA) has initiated an anti-smoking campaign designed to end tobacco sales in Canadian pharmacies.

The voluntary program — called Stand Up and Be Counted — was announced at the association's annual meeting here and will be cosponsored by Health and Welfare Canada (**The Journal**, April).

CPhA officials said 10% of Canadian pharmacies may eliminate tobacco sales during the first year of the program, which provides for three separate levels of commitment.

The first level calls for pharmacies to display anti-smoking posters and distribute brochures. The second will see druggists refusing to advertise or give prominent display to tobacco products.

The third and strongest level of commitment is when pharmacists refuse to sell tobacco products.

At least one major national pharmacy chain, though, is unlikely to support the campaign. Shoppers Drug Mart, with about 450 stores across Canada, is owned by Imasco, which in turn owns Imperial Tobacco, and has not committed itself to the program.

Shoppers Drug Mart president David Bloom says the company has no plans to stop promoting the sale of tobacco agents, because cigarettes are a legal product and "we can't act as public censors."

Most delegates at the meeting, however, backed up the campaign, although they were divided on its effectiveness.

One Ontario pharmacist noted that the federal government gave about $5 million in subsidies last year to Canadian tobacco growers. Until that stops, he said, the program is a "lost cause."

But another said she withdrew tobacco products seven years ago with little economic hardship. She said even smokers appreciated her action and felt it had increased awareness of the hazards of smoking.

And, CPhA president Stanley Lissack believes pharmacies that sell tobacco products do not adequately maintain their desired image as health promotion agencies.

Albert Liston, director general of Health and Welfare Canada, described the pharmacists' anti-smoking campaign as the most exciting collaborative venture yet in dealing with the tobacco problem, and he pointed out two particularly disturbing trends in Canada.

First, the age of the onset of smoking has declined to between 12 and 14 years of age from 16 years. Secondly, the increase in smoking rates by women in the 1950s is being reflected now by higher female lung cancer statistics.

Dr Liston said lung cancer will soon surpass breast cancer as the leading form of cancer mortality in Canadian women (**The Journal**, Sept 83, June). He also said two-pack-a-day smokers in their thirties now have a life expectancy nearly nine years shorter than non-smokers.

Despite the grim statistics, however, there are still more than seven million adult smokers in Canada. Dr Liston said there are also more than half a million daily smokers in Canada aged between 12 and 17.

"These young people are still being attracted to tobacco by the influence of smokers around them — their peers and parents," he said. "Yet the serious health consequences of smoking were first reliably documented over 30 years ago."

Dr Liston said the lesson of the past 30 years is that no one can make the tobacco problem disappear at once. But he said the problem can be solved slowly and surely by individuals, professionals, voluntary associations, businesses, and governments.

Dr Liston said he realized pharmacists are running businesses, but, as professionals in the health field, they also have a responsibility to discourage patrons from smoking.

Stand Up and Be Counted will run as part of the ongoing federal, Generation of Non-Smokers campaign aimed at Canadian youth (**The Journal**, May 1982). Dr Liston said other plans include national advertising, school programs and community-based education on the hazards of smoking.

BC butts out plan to end on-job smoking

VANCOUVER — A chain smoking provincial cabinet minister has stubbed out an initiative from the British Columbia. Medical Association (BCMA) to ban smoking in workplaces and public areas.

The association called for the ban at its annual general assembly here in early June. The BCMA resolution added that smokers should be provided with accessible areas where the smoke can be vented outside.

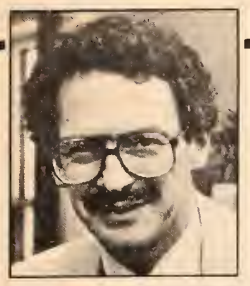
But health minister Jim Nielsen rejected the suggestion.

"People can, to a large degree, discipline themselves," he told reporters later. "You're not going to legislate an end to people's bad habits."

The assembly also passed a resolution calling for the labelling of alcoholic beverages (the sale of which is a government monopoly in BC) as a hazard to health.

Minister Nielson rejected that too.

COMMENT



GILBERT

'What is hurting tobacco growers as much as price hikes and politicking is the diminishing use of tobacco in cigarettes.'

Cigarette weights

By Richard Gilbert

The price and the weight of cigarettes are probably the two most important determiners of cigarette consumption in Canada. In May this year, I updated my April 1982 column on cigarette prices in which I had set out the almost relentless increase in per capita cigarette use between 1949 and 1980. Here I shall add to my May 1982 column, which concerned how the average weight of tobacco in a cigarette has changed, and how the change may have affected cigarette consumption.

In my May 1984 column, I argued that the tobacco industry has been right to attribute the 5.9% fall in per-capita cigarette sales in 1983 to increased taxes rather than to anti-smoking campaigns. I pointed out, too, that it was the anti-smoking campaigns that made the higher taxes politically possible.

It is now fairly clear that retail cigarette sales reached their highest point ever in 1981 — an average of 2,734 cigarettes for every Canadian — and that the future will be one of diminishing demand.

This spring there was an astonishing amount of media coverage of Canada's declining tobacco industry. The focus was on the plight of Ontario's tobacco farmers, who produce almost all of Canada's cigarette tobacco and a substantial surplus for export.

In 1983, Ontario tobacco production was 98,500 tonnes — down from 108,000 tonnes in 1982. Of the 1983 crop, 58,500 tonnes was used domestically and 40,000 tonnes was reserved for export, of which 4,500 tonnes remained unsold.

In April this year, the tobacco farmers were hit with a double blow. They learned that Canadian tobacco manufacturers would require only 45,000 tonnes in 1984 (down by 23%) and that only a further 19,000 tonnes would be bought from them for export (down by 53% from the amount purchased from farmers for export in 1983). Overall, the 1984 crop is to be limited to 64,000 tonnes — a fall of 35% from 1983.

Political activity

There was a flurry of political activity. Ontario's agriculture minister headed an unsuccessful trade mission to Britain to boost flagging sales. Members of the Liberal party in the Ontario legislature (whose strength is in the south-west of the province, where most of the tobacco is grown) secured an emergency debate on the matter. They complained that the minister "should be doing something to reduce the outrageous and injudicious level of taxation to a point where it will stop depressing the market."

The other opposition party, the New Democrats, took a different tack. They argued that the Conservative government's policy of trying to aid domestic farmers by promoting exports is reprehensible because it is exporting cancer.

The provincial government was due to present its 1984-85 budget on May 9. There was considerable hope among tobacco interests that tobacco taxes would be reduced. Cigarette manufacturers had been lobbying for months. The provincial treasurer had hinted in January that taxes on both alcohol and tobacco might be cut. I suspect that the manufacturers sharply reduced their proposed purchases from growers this year — making up the difference from stocks — to force the growers to pressure the Ontario government into reducing taxes.

To my surprise, and that of the industry, the May 9 budget left tobacco taxes unaltered. Ontario continues to have the second highest rate of taxation of cigarettes in Canada — after Newfoundland.

What is hurting tobacco growers as much as price hikes and politicking is the diminishing use of tobacco in cigarettes. In May 1982, using mostly United States data, I noted how the amount of tobacco per cigarette had been falling since the early 1950s. I suggested this decline had been partly responsible for the increase in the number of cigarettes smoked by each smoker, and thus for the paradox of rising sales in the face of fewer smokers. The weight of tobacco per US cigarette fell by 15% during the 1950s, by 14% during the 1960s, and by 13% during the 1970s, the total decline from 1950 to 1980 being 36%.

I was not aware of data on the average weight of tobacco in Canadian cigarettes when I wrote my May 1982 column. Since then I have seen an article by Nelson Longmuir in the Spring 1982 edition of *The Lighter*, a publication of Agriculture Canada, that gives data on the amount of tobacco used in the production of 1,000 cigarettes from 1949 to 1981, with a projection to 1991.

This article, and a supplementary table prepared by Mr Longmuir, suggest a 54% decline in the weight of tobacco used to make a cigarette between 1949 and 1981. The 1949 amount was 1.88 grams per cigarette. The 1981 amount was 0.87 g. Thus, although per capita consumption of cigarettes in Canada increased from 1,252 to 2,734 between 1949 and 1981, an increase of 118%, the increase was almost precisely offset by the decline in the amount of tobacco used per cigarette. The result was that the per capita use of tobacco for cigarettes in Canada in 1981 was 2.39 kilograms — almost exactly the 1949 value of 2.36 kg.

Mr Longmuir projected that the amount of tobacco used to make the average cigarette will continue to decline — to 0.79 g in 1991. It is this decline, and the new fact of falling cigarette consumption, that cause much of the problem faced by the tobacco growers.

Unrealistic expectations

The rest of the tobacco growers' problem arises from unrealistic expectations of growth in exports in the face of declining cigarette use in most developed countries and competition from Third World tobacco growers. During the past two years, substantial tax increases in countries as different as Argentina, Brazil, Britain, China, Sweden, the US, and West Germany, as well as Canada, have all produced reductions in per capita cigarette consumption.

As well as working through the Liberal party members of the Ontario legislature, farmers in the south-west of the province are fighting on other fronts to ensure continued use of their land for the extremely profitable purpose of growing tobacco. In response to their pleas, the federal agriculture minister has promised the creation of a national agency through which growers could set prices and control imports.

Tobacco growers are now militantly opposing municipal involvement in anti-smoking campaigns, and proposals for municipal bylaws that would limit smoking. They sport bumper stickers and baseball caps bearing the slogan "My pleasure — my choice" below a green cigarette symbol. We are seeing the beginnings of a smokers' rights campaign in Canada.

There is a considerable difference between the decline in US use of tobacco per cigarette between 1950 and 1980 of 36%, noted above, and the apparent Canadian decline of 54% during a similar period. I spoke with representatives of Imperial Tobacco and Rothmans to find out more. Surprisingly little information seems available as to how much tobacco has actually been used in cigarettes over the years.

Bob Wade of Imperial Tobacco said that as a rule of thumb 25 cigarettes of average length weighed an ounce in the late 1940s. Ignoring the slight amount attributable to paper, this means that the average cigarette contained 1.13 g of tobacco. He noted further that there was a strong incentive to keep weight down because cigarettes weighing more than 2.5 lbs per 1,000 (ie, more than 1.13 g each) were taxed at a higher rate. Today, he said, the typical cigarette (king-size with filter) contains 0.86 g of tobacco.

Peter Bone of Rothmans told me that their king-size, filter cigarettes contained 0.97 g of tobacco in 1974 and contain 0.81 g today.

Thus, it would seem that the weight of tobacco in a cigarette in Canada has fallen to around 0.85 g in 1984 from around 1.15 g in 1949, a decline of 26%, and that the rate of decline across the years has been at a fairly constant rate of near 9 milligrams a year. (These values are close to the US values alluded to above, which were 1.22 g of tobacco per cigarette in the early 1950s and 0.77 g today.)

Discrepancy

The discrepancy between the two sets of figures, those of Mr Longmuir and those of the tobacco companies, lies almost certainly in the way in which the cigarette manufacturers have used tobacco leaf. In 1949, they bought 1.88 g of tobacco leaf for each cigarette they made, but only 1.15 g finished up in the cigarette. Now they buy 0.85 g of tobacco for each cigarette, and virtually all of it is used.

This means that although the tobacco growers are selling no more tobacco per capita for cigarettes than in 1949, the actual consumption of tobacco in the form of cigarettes by the average Canadian has increased substantially — from about 1.44 kg per person in 1949 to 2.39 kg in 1981, an increase of 66%. Moreover, this difference does not take into account the growth in use of filter tips in the 1950s and 1960s, which led to more of the tobacco in a given cigarette being consumed.

In 1949, manufacturers used mostly only the best part of the tobacco leaf to make cigarettes. Now they use everything, including the stem and any dust created during processing.

Tobacco is treated in an amazing variety of ways to ensure both that more of the plant can be used and that what is used fills the paper tube as economically as possible. It is shredded and reconstituted using a process not unlike paper-making. Techniques for increasing the filling power of tobacco, in use and proposed, include treating it with enzymes, impregnating it with solid carbon dioxide, fiberizing tobacco stems, and roasting the leaf after soaking it in an alkaline, hydrogen peroxide solution.

The move to cigarettes yielding less tar and nicotine has helped the cigarette manufacturers in their quest to use less tobacco and to use the plant more efficiently. For a given style of filter, tar and nicotine yields correlate fairly closely with tobacco weight.Thus reducing tobacco weight is good for sales if low-yield cigarettes are in demand. Cynics say that the manufacturers created the demand for low-yield cigarettes so that they can use less tobacco per cigarette and make more profit.

It is also clear that smokers smoke more cigarettes when yields are lowered. A graphic example of this occurred in Greece where the tobacco content of cigarettes was reduced by some 25% in 1981: cigarette consumption went up for the first time in 15 years. In North America, the gradual reductions in tobacco weight over the decades have likely had the effect of getting smokers to share out a given amount of tobacco over a greater number of cigarettes, thereby increasing cigarette purchases.

Mysterious flavors

One result of all the treatment of tobacco and filtering of smoke is that cigarettes tend not to taste as they should without further operations to enhance flavor. Flavoring is one of the real mysteries of the cigarette-making process. Patents for flavoring chemicals registered in the US give a clue. In 1983, they included a substance to impart "fresh, oriental, spicy, floral, citrusy flavor and aroma nuances," another to add "fruity, berry-like, woody, and floral characteristics," and a third to provide "specific oriental, fruity, rum-like, and Turkish tobacco-like notes."

Yet another ruse being suggested is the addition of tobacco to the filter to enhance the taste of low-tar cigarettes. Tobacco growers would be enthusiastic about this idea. They would also welcome the beginnings of an apparent revolt among smokers against low-tar cigarettes of any kind. Cigarettes are not like they used to be, some smokers seem to be saying. Cigarette manufacturers have gone too far.

In England in the late 1940s, Weights and Woodbine cigarettes were the preferences of poorer smokers. Near pay day I would be sent out to buy a pack of five Weights (the marginally classier brand), and pretend they were for me. Mr Woodley, the local tobacconist, knew the kids didn't smoke much on Thursdays or any other day — they couldn't afford to — but he needed the custom, maintained the pretence, and kept a good supply of fives in stock. In better times, my mother switched to Craven A, sold only in 10s and 20s. Part of the attraction of Craven A was the filter, then an embellishment rather than a risk reducer, preferred because it kept the shreds of tobacco out of her mouth. A filter meant no wasted butt, no temptation to recycle it into another cigarette.

As well as returning to the days of weight-tier cigarettes and tobacco close to the mouth, we may also be seeing smaller packs. The Reynolds Company in the US is said to be introducing packs of 12 cigarettes for use in machines. They would soften the effect of large, tax-driven, price hikes. Peruvians buy their cigarettes in ones and two from kids who cruise street corners and restaurant tables with open packs. As the tobacco industry approaches its last breath in North America, the practice of cigarette smoking is reversing through its phases of development, regressing through stages just being reached in other parts of the world.

Tobacco growers' slogan: the beginnings of a smokers' rights campaign in Canada?

NEWS

Drinking during pregnancy is down, says Streissguth

Women are responding to warnings on FAS

By Heather Walker

SEATTLE — Awareness of fetal alcohol syndrome (FAS) and other possible birth defects have led to a reduction in the number of women who drink during pregnancy, says Ann Streissguth, PhD.

Dr Streissguth, a psychologist at the University of Washington here, was one of the first people to recognize FAS.

"There have been changes in drinking during pregnancy," she told participants at the National Research Conference on Women and Alcohol. "In Seattle in 1974-1975, only 19% of women were not drinking during pregnancy. Now, 58% of women don't drink while they are pregnant."

Dr Streissguth said concerns about the effects of alcohol on the developing fetus have grown to include moderate drinking as well as heavy drinking.

"Generally we only find FAS with women who are alcoholic, but even without an FAS diagnosis, there can be a lowered IQ," she said. "Even with a couple of drinks a day, or a couple of drinks a week, there is a greater risk of spontaneous abortion, stillbirth, or small head circumference."

She added that some fetuses are apparently more susceptible to FAS than others, pointing to a case of fraternal twins born in France to an alcoholic mother. One twin has the syndrome and is severely retarded; the other is normal.

Dr Streissguth said a diagnosis of FAS "indicates a child at risk and a mother at risk.

"The mothers are at risk because of alcoholism — often untreated alcoholism. Children with FAS are at risk because of failure to thrive, possible neglect, hyperactivity, learning problems, heart problems, ear problems, and other health problems."

She said it is important to monitor all children, not just the children of alcoholic mothers, at birth for the symptoms of FAS or other alcohol-related effects.

"And it is important to monitor these children and provide help for their parents in dealing with hyperactivity, because these children are difficult to raise. It's important to encourage pre-school attendance and facilitate proper schooling, and to provide alcohol treatment for women.

"Many of these children are adopted, and it's also important to realize that the adoptive parents of FAS children also need support networks."

Dr Streissguth said that while the frequency of FAS in the population is low, "it is at least doubled if you consider partial effects. There is some alcohol effect in one of every 300 births, which is quite a lot."

She said there is now some work being published on the syndrome on Indian reservations, and it shows different percentages of prevalence. On some, it is found in only one of every 750 births. On others, one of every 100 children has the full syndrome and the level rises to one out of 50 if children with partial FAS are included.

Dr Streissguth told **The Journal** she first saw the syndrome in 1973.

"My background is in child development and developmental and child psychology, and I have a lot of experience examining babies," she said. In 1973, two Seattle pediatricians, Dr David W. Smith and Dr Kenneth Jones, asked her to examine eight children ranging in age from three months to four years, all with alcoholic mothers.

"They all had serious developmental problems and intelligence handicaps which seemed organically-based," she said. "I was surprised to see how they all looked, so I did a literature search on the effects of alcohol on the fetus and couldn't find anything.

"We presented the work we were doing at the National Conference on Alcohol, and then we were besieged with calls from people about what the effects were from social drinking, and we had no idea what the answer was.

From there, work continued on comparing children of alcoholic mothers with children in similar environments but with non-alcoholic mothers, and "there were horrendously increased risks with the alcoholic mothers."

Dr Streissguth is now working on a longitudinal study of 500 children in the Seattle area. The majority are children of heavy drinkers, with a sampling of children from other backgrounds for comparison.

Fetal cerebellum vulnerable

BOSTON — Cognitive and psychosocial problems in children with fetal alcohol syndrome (FAS) appear to be caused by frank neurological abnormalities, says a Brooklyn, New York, neurologist.

Although physical and intellectual abnormalities characteristic of FAS — severe growth retardation, facial deformities, microcephaly, and mental retardation — have been well described during the past decade, there has been little study of formal neurologic abnormalities in children with FAS, says Joseph Marcus from the Downstate University of New York.

He said in an interview here at the annual meeting of the American Academy of Neurology that in the course of examining children with developmental and learning problems, he found five with FAS ranging in age from 2.5 to 10 years, with cerebellar abnormalities.

Dr Marcus said he believes cerebellar disease in FAS children is a common, overlooked feature of the syndrome.

"Considering the known effects of acute and chronic alcohol intake on the brain in adults, it really is not surprising to find central nervous system abnormalities in FAS children," he said.

"Rather, one wonders why they haven't been reported before. FAS, or indeed alcohol, is not mentioned in any recent text as a cause of cerebellar disease in children."

Estimated incidence of FAS in North America is one case per 750 live births. In this light, Dr Marcus said his findings have important social, personal, and financial implications.

"In children with neurological signs where there is a history of maternal drinking during pregnancy, and particularly if there are other features of FAS, extensive investigation is unnecessary," he said.

"The knowledge that cerebellar damage is the cause of neurological symptoms in FAS children can result in considerable savings in time, money, and hospitalization — for the child and the health care system."

Dr Marcus said his findings emphasize the serious problems posed by maternal drinking during pregnancy: "We have a large population of children who are retarded and otherwise impaired because their mothers could not or would not give up drinking during pregnancy. This is already known, but must be promoted more."

Mothers of children in Dr Marcus' series drank heavily during their pregnancies. Their children were severely growth-retarded and had varying degrees of facial abnormalities. Two have microcephaly, three are mentally retarded, and two of the children had seizures.

The neurologic finding of kinetic tremor was constant in all five children. All have problems with muscle coordination, especially in performing simple tests such as standing on one leg, hopping, and walking with a normal gait. Three have speech problems and impaired motor impulse function.

"The neurological signs are all restricted to the cerebellum," Dr Marcus said. "This is not too surprising since it is well known that alcohol has a profound effect on the cerebellum," which is especially vulnerable during two critical points during gestation.

Marcus: two vulnerable times

At three months, formation of the pontine flexure results in the cerebellum being the biggest part of the fetal brain until the rest of the brain starts to grow about halfway through pregnancy. Growth peaks during the third trimester and ends around the time of the child's second birthday.

"The cerebellum continues to grow faster than the rest of the brain throughout these spurts, with the most rapid growth occurring during the third trimester," Dr Marcus said. "It is thus most vulnerable at two developmental points — at three months and in the third trimester."

Personal plea to parents abroad would boost anti-drug battle

By Harvey McConnell

ATLANTA — International drug trafficking can only be eventually solved by action in the source countries, says Peter Bensinger, former director of the United States Drug Enforcement Administration (DEA), now a private consultant to industry.

He said here: "My sense about international drug trafficking is that the law enforcement agencies are not going to really effectively control this problem, although heaven knows we have tried and lost some good friends in the battle."

He told the international conference of the PRIDE parents movement he would like to see moves made on a personal, rather than governmental, level where people reach out to parents in source countries "who have their own kids at stake and at risk."

In addition, he said, parents and businessmen should talk to their counterparts in Western Europe, Latin America, the Far East — "People who pay taxes and have kids at risk. The pressure should come from there, from the ground up."

Mr Bensinger said success in attacking drugs at the source has been proven. In April, 1976, Mexican heroin was flooding the US, purity was 6.6%, and there were some 200 overdose deaths a month. Then, with the US, Mexico launched an opium poppy and marijuana eradication program, destroying some 80,000 fields.

On US streets, within a few years, the supply of brown (Mexican) heroin dropped from six tons a year to just over a ton a year, purity was halved, the price almost doubled, and the number of heroin users dropped from 700,000 to around 400,000.

Now, Mr Bensinger said, unless similar programs are carried out in South America, little can be done to reduce cocaine and marijuana trafficking.

In the Gaujira Peninsula on the north coast of Colombia there are some 100,000 acres of marijuana under cultivation. And, its estimates show that in 1984 the US will be hit with 100 tons or more of cocaine: a 100% increase over the estimated 50 tons which entered the country in 1983.

Pain-relieving capabilities of household analgesics misunderstood: Lasagna

VANCOUVER — Despite their popularity and undeniable usefulness, the analgesics ASA and acetaminophen are still not fully understood by researchers.

Louis Lasagna, MD, professor of medicine at the University of Rochester, told the Canadian Pharmaceutical Association (CPhA) annual meeting here that considerable ignorance remains about the use of the two drugs in managing pain.

Many people insist the drugs are good only for mild relief, but Dr Lasagna said they can be useful, nonetheless, in controlling certain kinds of moderate to severe pain.

He said in single dose studies, ASA and acetaminophen generally surpassed the analgesic performance of codeine and propoxyphene (Darvon) and also noted that salicylates can be co-administered with codeine or propoxyphene to "top up" the analgesic effect.

(ASA [acetylsalicylic acid] is also known as aspirin. In Canada, however, it is sold under the proprietary name, Aspirin. Tylenol and Panadol are two popular brand-names for acetaminophen.)

Dr Lasagna also claimed it is an "academic cliché" that ASA is anti-inflammatory while acetaminophen is not, citing recent studies showing that acetaminophen can reduce pain and swelling from certain kinds of dental surgery.

He also said researchers have overstated the corrosive effects of ASA on the stomach. It can produce gastric ulceration, but any anti-inflammatory drug can produce that effect in experimental animals.

"It can happen but, on the whole, it isn't a terribly common phenomenon," Dr Lasagna continued.

Studies have shown, however, that regular ingestion of ASA by pregnant women could delay onset of labor and increase its duration, he said. As well, increased bleeding problems could result with infants or mothers during childbirth.

He added another interesting side effect of ASA was discovered during a recent Yale University study, which found long-term ingestion of ASA may delay the onset of cataracts.

Pervasivness of drinking hinders alchoholics' rehab

MONTREAL — Alcoholics could be rehabilitated more successfully if other people in society were more willing to say no to a drink, says a scientist with the Addiction Research Foundation (ARF).

Harold Kalant, MD, PhD, director of biobehavioral research at the ARF and professor of pharmacology at the University of Toronto, says alcoholics respond in the same way as normal drinkers to socio-economic factors.

"A society that would give more approval to the refusal of alcohol rather than its consumption, and that would not present a great number of occasions to remind one of alcohol every day, would offer significantly less risk for the person who is trying to rehabilitate into a healthier life without alcohol," he says.

Drinking can lead to peer reinforcement, Dr Kalant says. "A person who does not use alcohol may end up more or less isolated, whereas a person who accepts alcohol gets the approval of the other members of the group, which is highly reinforcing.

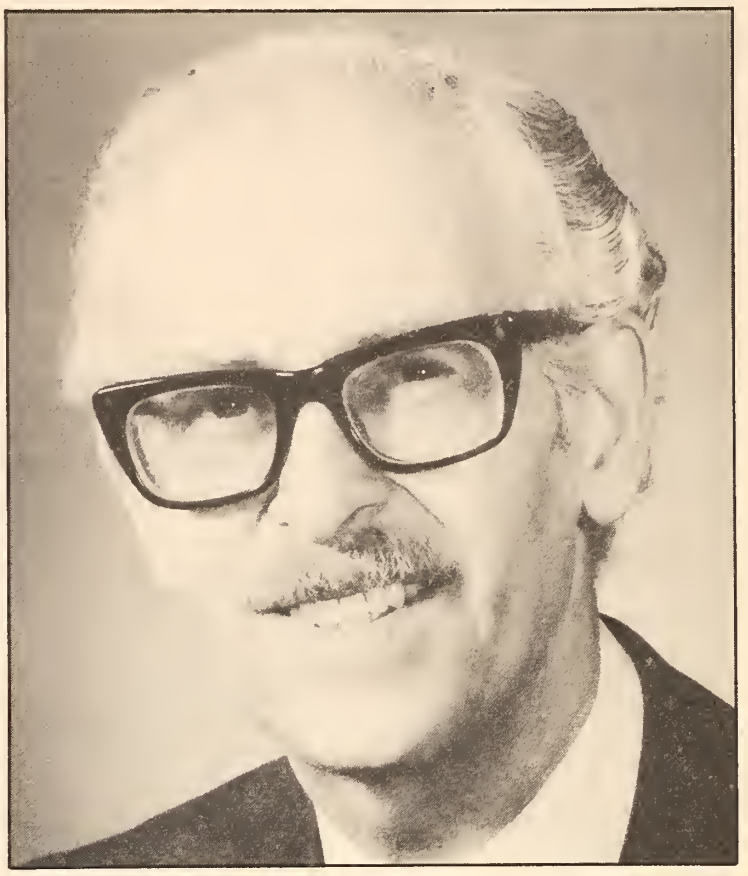
"Alcohol thus becomes a conditional stimulus which gives drinkers the same reinforcement as social approval."

Research shows that as society increases the frequency of drinking occasions by lowering prices or making alcohol consumption more acceptable, it "also increases the probability of (the alcoholic's) relapse," he said at a conference on Alcoholism and Other Drug Dependencies here.

Dr Kalant says studies show that as the average rate of alcohol consumption increases, so does the incidence or prevalence of disease associated with drinking.

When society tends to favor higher alcohol consumption generally, "a person who refuses alcohol is seen as a little strange," Dr Kalant says. Another effect is that "the excessive drinker or alcoholic is free to drink more when in the company of other people whose behavior does not absolutely differ from his own."

Peer approval and the pharmacological effects of alcohol can reinforce the desire to drink, he says. Advertising, the physical, drinking environment, and the smell and taste of alcohol can also contribute to relapse.



Kalant: 'a person who refuses alcohol is seen as a little strange'

"A policy to control sales and prices, and a reduction in certain forms of advertising of alcoholic beverages, would facilitate the rehabilitation of treated alcoholics for the same reasons that they would help to reduce the incidence of alcoholism."

Nevertheless, Dr Kalant says individuals must also share the responsibility. People can change friends, lifestyle, and work if they are associated with alcohol.

"Perhaps the most important factor, on a long-term basis, would be an education program whose goal would be to change people's attitudes of acceptance of alcohol consumption."

Such an information program was successful in France, he says. A program which, in part, convinced people that children shouldn't drink wine was strong enough to lower the average alcohol consumption there, Dr Kalant adds.

However, government programs can be costly. Alcohol accounts for a sizeable amount of government revenue, creates jobs, and is "a source of pleasure" for many people, he says.

"In order to protect the vulnerable people, these economic and personal advantages would have to be denied as well, and, in a democratic society, that would mean the end of any government that would dare to apply such measures of public health.

"The challenge facing us is to decide the price we are prepared to pay to protect those among us who are incapable of protecting themselves."

Nurse counsellor service offers part-time help to 'branch plant' employees

By **Jon Newton**

TORONTO — Our Employeecare nurse realized I was having trouble with drinking . . . she helped me to see a doctor. I quit drinking for five months. I now have an occasional drink. She sees me every Wednesday, and I keep going to my doctor. I feel a lot better now. Joe."

That message was sent recently to Betty Dods, president of the unusual corporation here that helped Joe.

Founded two years ago by a group of nine determined and experienced occupational health nurses, Employeecare Ltd set out to fill a gap left in small businesses as, increasingly, in-house employee assistance programs (EAPs) got plugged into large industries and businesses — often through cooperative effort of large staffs and enthusiastic and wealthy managements.

The movement rolled right by many small businesses and local branch offices that couldn't afford large, in-house programs or medical and para-medical staff.

So Dods and company went to work — offering a range of health services, including counselling and help organizing programs, to small businesses and "branch plants" on a low-cost, part-time basis.

Preventive medicine and safety programs are the two areas the nurses concentrate on, says Ms Dods. That, and rehabilitation.

But, more and more, they are finding substance abuse is cropping up as a problem in their day-to-day work.

She tells of the young alcoholic in a small industrial unit whose friends passed bottles to him through a fence when he was on the night shift. His job was in serious jeopardy until Employeecare was able to work with the company manager and persuade the man to get help.

Today he is well on the way to recovery; also he still has his job.

A young mother whose husband was recently released from jail was afraid he might return to using drugs. Counselling provided the woman with the reassurance, personal advice, and friendship she needed. She now works, and still regularly meets with her Employeecare nurse.

Says Ms Dods: "We see nursing activities as being at the centre of things. Maybe that's just our geocentric view of the universe, but we bring in services like EAPs, safety, medical help, industrial hygiene, and so on.

"Ours is a customized service for smaller plants, and we're usually the ones who put it all together, because small companies don't usually have safety or health professionals, and they don't have their own programs."

The nurses work in a wide range of settings. One current, and new, contract is with the City of Toronto Sewage Plant; another is with the Hilton hotel near Toronto's international airport.

Every Thursday, nurse and group partner Carolyn McCulloch goes to the Hilton and opens her office, ready to deal with whatever comes up.

Hotel manager Ed Robinson told **The Journal**: "Our Employeecare nurse is helpful both in terms of keeping tabs on the health of our staff, and also by following up on things like worker's compensation.

"She sees all staff who report sick, for whatever reason, and also interviews new staff. This is all part of Hilton International's policy of looking after employees. We believe healthy people make running a good show easier, and our company is concerned with employees' welfare and well-being.

"Employeecare helps us to make sure of this."

Meanwhile, says Ms Dods, the company is flourishing and seeking new, experienced nurses to keep pace.

"We started with a handful of clients," she explains, "but now we're increasing our base very nicely and steadily. The larger firms tend to be fairly well looked after, but not the smaller companies.

"We're still expanding, and the need seems to be almost infinite."

Dods: need seems infinite

Preconceptions hamper prognosis

Female drinker theories untested

SEATTLE — The belief that women have a more difficult time recovering from alcoholism than men may contribute to a poor outcome for female patients.

Although few studies have compared men and women alcoholics, assumptions are nevertheless made about women's treatment and prognosis, says Martha Vannicelli, PhD, an assistant professor at Harvard Medical School, Cambridge, Massachusetts.

"They are commonly seen as harder to treat and as having a poorer prognosis," she told the National Research Conference on Women and Alcohol here.

"I'll give you an example of one woman who was discussed in a session at which I was present," she said. "Her therapist said this woman was having a very bad time, disrupting meetings and behaving in a very infantile manner. He described her as an infantile, dependent lady. I asked him what she was like, and he said she was a delightful, lovely-looking little girl. "When I asked him for more details, it turned out this delightful, lovely-looking little girl was 32 and the head of a social services agency . . . . she was actually a very competent person.

"I suggest the fact that he saw her as a delightful little girl made a difference in the way he was dealing with her behavior."

Dr Vannicelli estimated that in the past 30 years, only 3,000 women, as a group, have been studied separately from men and followed for a period of six months. In other studies, women were not included, or data on them were integrated with those on men. Researchers also excused their failure to follow-up women patients by saying women tend to change their names and are thus more difficult to find than males.

Dr Vannicelli said she had found no real evidence that women have a poorer prognosis than male alcoholics, or that they benefit more from treatment by women therapists or in all-women treatment programs. But, she said, research leaves the assumptions untested.

Attorney-General Smith denies infighting reports

WASHINGTON — Attorney-General William French Smith has rebutted claims of friction among agencies in the United States' administration's fight against drug trafficking and said "coordination and cooperation is outstanding."

In hearings before the Senate appropriations committee, he shrugged off a five-month-old internal memo which claimed there was conflict.

Told by Democratic Senator Dennis DeConcini "you're not in touch with what is going on," Mr Smith snapped back: "I do know what is going on. I have been intimately connected with it. In terms of what we are doing, what we have produced, the coordination and cooperation is outstanding."

Smith: cooperation outstanding

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Jon Newton (Toronto)
Tim Padmore (Vancouver)
Lynn Payer (New York)

Member of ccab and cbp

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Addicted baby findings informative

I thought the article, Addicted Mothers and Babies, on the Back Page of the April issue of The Journal was very interesting and informative. Would you please send me the references for this article.

Ruth M. Stewart, RN
Nurse Supervisor
Drug Addiction Services of
Hawaii, Inc
Honolulu, Hawaii

In your April issue, an article entitled Addicted Mothers and Babies, was featured on the Back Page. In this article, several places were mentioned that are currently conducting research into this problem.

I am a second-year student at George Brown College of Applied Arts and Technology, in the addiction counsellor program. In the near future, I will be preparing a paper on Infants of Narcotic Addicts (INAs).

I have enclosed a list of places that were mentioned in this article and am requesting the addresses and possible contact persons I can write to in order to obtain information pertaining to INAs.

Thank you.

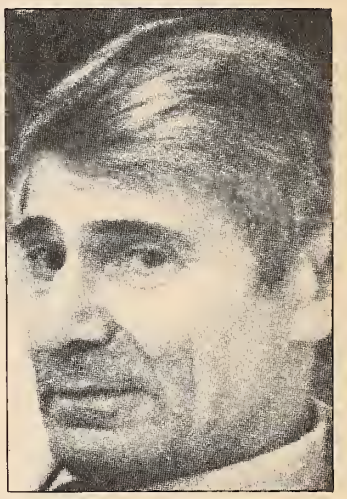
Nancy Price
Toronto

May I please have a copy of the April issue of The Journal in which there is an account of Professor Sydney Segal's work in Vancouver, as well as the references for the Back Page article, Addicted Mothers and Babies?

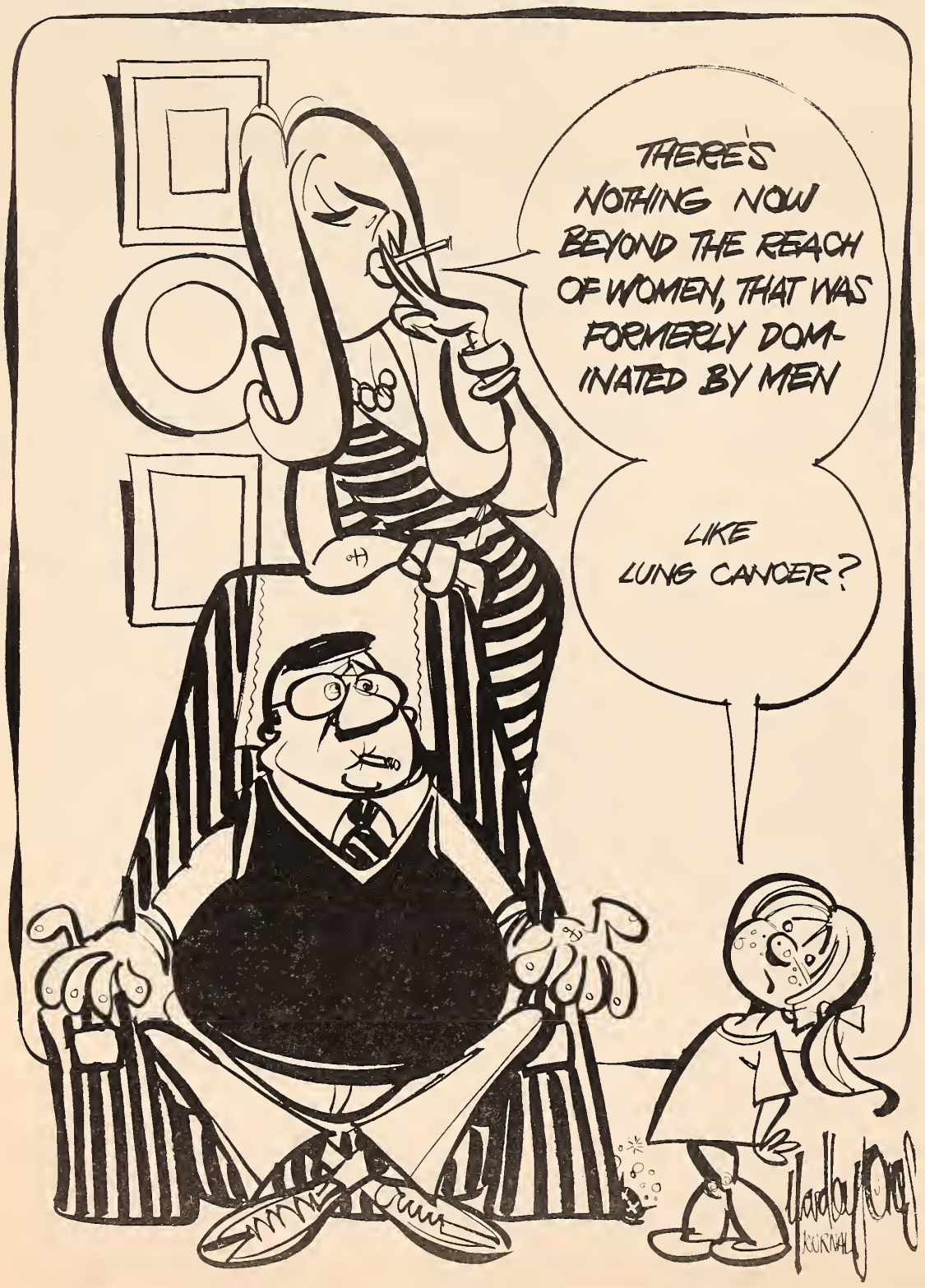
My findings in London are similar to Professor Segal's.

Elizabeth Tylden, MA, MB, Bch, MR Coll Psy
University College Hospital
Obstetric Hospital
Huntley St
London, England

Editor's note: Reference information has been forwarded.



Segal



Rumor was incorrect

In a letter published in the May issue of **The Journal**, I outlined some criticisms of an article entitled Tobacco company sponsorship — Is it sporting? by Jon Newton (**The Journal**, March).

In have now heard that Mr Newton was formerly associated with the Canadian Ski Association (CSA) and was the individual who was principal in bringing together the CSA and RJR-MacDonald Tobacco.

This is nothing more than rumor, but I should like, for my own peace of mind, to have you clear up what must surely be a misunderstanding.

Although I do not agree with the article written by Mr Newton, I am confident that neither the author nor **The Journal** would represent the issue dishonestly. **The Journal** is, generally speaking, to be commended for its wide and full coverage of issues relating to smoking and health.

I should like to hear your comments.

David Nostbakken, PhD
Director of Public Education
Canadian Cancer Society
Toronto, Ontario

Editor's note: Jon Newton's association with the Canadian Ski Association (CSA) and the RJR-Macdonald Tobacco Company, as well as with individuals in both groups, began when, as a correspondent for **The Journal**, he set out to cover the events he wrote about in the March issue.

Mr Newton has confirmed this as have Greg Hilton, executive director of the CSA, and Jeff Goodman, director of public affairs for RJR-Macdonald.

Mr Hilton did explain that the previous (to him) executive director of the CSA was a John Newton. Not even that Mr Newton, however, was responsible for developing the link between the CSA and RJR-Macdonald; Mr Hilton claims that initiative as his own.

Regina police say TJ 'invaluable' for youth work

I have been receiving **The Journal** for some time now and I find it very informative. Two members of the Regina Police Service, whom I work with concerning school safety patrols, saw the last issue of **The Journal** and were very impressed. They thought **The Journal** could be invaluable when dealing with the school children every day of the week.

I wondered if they might be put on **The Journal**'s mailing list? I would appreciate it very much.

Thank you for the work you do.

Bob Newton
Public Relations
Saskatchewan Motor Club
Regina, Saskatchewan

Editor's note: Subscription details have been forwarded as requested.

Correction

A line was inadvertently left off the article, Newer perspectives on the health of Canadians: Beyond the Lalonde report (**The Journal**, May).

The final paragraph (page 9) should have read: The reported annual incidence of those infectious diseases which are preventable by immunization should be reduced as follows:

The Journal welcomes Letters to the Editor. Letters bearing the full name and address of sender may be sent to: The Journal, 33 Russell St, Toronto Canada M5S 2S1.

Drugs and the law

-Canada's federal drug laws-

By Robert Solomon and Sharyn Langdon*

Section 1 — Introduction

There are two major federal statutes in Canada dealing specifically with unlawful drugs — the Narcotic Control Act (NCA) and the Food and Drugs Act (FDA). Although these are the most important federal drug acts, other federal statutes create crimes involving drugs. For example, the Criminal Code makes it a crime to drive while a person's ability to do so is impaired by alcohol or another drug.

The NCA and the FDA each set out offences and penalties, and contain some special police powers. However, the Acts do not refer to police powers of arrest, appeals, or many other procedural aspects of a criminal case. These matters are governed by the Criminal Code, which contains the major body of federal criminal law and procedure. There is a federal law which, in effect, applies the Criminal Code's procedural provisions to offences created by other federal statutes. Consequently, many of the Criminal Code procedural provisions apply to offences created by the NCA and the FDA.

Before turning specifically to the federal drug Acts, it is necessary to understand the classification of federal offences. All federal offences may be divided into one of three categories: summary conviction offences, indictable offences, and dual procedure offences. The prosecution is given discretion in dual procedure offences (also referred to as "hybrid" or "crown electable" offences) to proceed either by summary conviction or by indictment. Once this decision is made, the case is treated like any other summary conviction or indictable offence, depending on which procedure the prosecutor has chosen.

The Criminal Code contains basically one set of procedures for summary conviction offences, and another set for indictable offences. As a general rule, the more serious crimes are indictable, and this is reflected in the nature of the procedures. For example, police are given broader powers of arrest for indictable offences than for summary conviction offences. The trial procedures used for indictable offences are more formal and complex than those which govern summary conviction offences.

The prosecutor's exercise of discretion in dual procedure offences may affect not only the procedures, but also the sentence. Dual procedure offences generally provide two maximum sentences — one if the case is tried by summary conviction and a second, usually heavier, maximum sentence, if the case is tried by indictment. For example, cannabis possession is a dual procedure offence. If tried by summary conviction, possession carries a maximum sentence of six months' imprisonment and a $1,000 fine for a first offence. However, if tried by indictment, possession carries a maximum sentence of seven years' imprisonment.

Section 2 — The History of Federal Drug Laws

Prior to 1908, few restrictions were imposed on the sale or use of drugs, whether they were intended for medical or non-medical purposes. Canada annually imported tons of raw opiates. Drugs of all kinds were widely distributed by doctors, travelling medicine shows, patent medicine companies, pharmacies, general stores, and Chinese opium shops. Drug addiction was not viewed as a criminal matter, but rather as a personal weakness or vice.

(a) Origins of the Narcotic Control Act

The first federal criminal law arose out of concern about opium smoking among the Chinese. During the 1860s and 1870s, Chinese workers were welcomed to the Canadian west coast because they provided a cheap, reliable source of labor for the developing railroads and mines. The Chinese workers' preference for opium rather than alcohol was of no concern. Attitudes toward the Chinese and opium smoking changed quickly in the 1880s, when an economic decline greatly reduced job opportunities. The Chinese were accused of taking jobs away from white workers, and there were strong and bitter demands to end Chinese immigration. The federal government responded by establishing two royal commissions and by imposing a special tax on Oriental immigrants.

Racial tensions continued to mount and, in 1907, white workers rioted and attacked Oriental businesses in downtown Vancouver. William Lyon MacKenzie King, the federal official who investigated the riot (later Canada's long-serving Prime Minister) was shocked to discover the existence of a well-established and legal Chinese opium trade. He filed one report on the riot, and another report condemning opium smoking. Shortly after his opium report was received, Parliament passed the 1908 Opium Act, making it a crime to import, manufacture, offer to sell, sell, or possess to sell opium for non-medical purposes.

Difficulties in enforcing the 1908 Act and alarm about other drugs led to the enactment of a more comprehensive statute in 1911. Cocaine, morphine, and other drugs were added to the list of prohibited substances, special police powers were enacted, and possession and other offences were created.

Another series of changes was made during the 1920s. Police powers were greatly expanded and severe penalties were enacted including, for some offences, hard labor, whipping, and mandatory deportation of convicted aliens. The rights of drug suspects were limited, new offences were created, and marijuana and other drugs were added to the schedule of prohibited substances.

Although further changes were made between 1930 and 1960, the current NCA resembles the 1929 legislation. The Act still governs opiates as well as other drugs that are not narcotics, and it still contains severe penalties and broad enforcement powers.

(b) Origins of the Food and Drugs Act

Although the predecessors to the FDA can be traced back to the last century, the sections dealing with non-medical drug use are relatively new. Until the 1960s, the FDA was primarily concerned with ensuring that foods, cosmetics, medicines, and medical devices were produced in sanitary conditions, were safe for human consumption and use, and were honestly advertised. The federal government added new parts to the FDA in the 1960s to deal with the increased non-medical use of LSD, amphetamines, barbiturates, and other drugs.

Section 3 — The Present Narcotic Control Act

There are now approximately 100 different substances listed in the Schedule to the NCA. Each is a narcotic for legal purposes and each is subject to the provisions of the Act. The federal government can change the schedule by order in Council.

Except for the offence of cultivation, which applies only to opium and cannabis, the Act does not distinguish among the drugs in its Schedule. For example, cannabis and heroin offenders are subject to identical police powers, processes of fingerprinting and photographing, penalty provisions, and criminal record consequences. A relatively small number of drugs, namely cannabis, cocaine, phencyclidine (PCP), and heroin account for virtually all of the charges under this Act.

The Act contains five common offences: possession of a narcotic (often referred to as "simple possession"); trafficking in a narcotic; possession of a narcotic for the purpose of trafficking; importing or exporting a narcotic; and cultivation of opium or cannabis. In addition, we will examine an offence commonly referred to as "prescription shopping" which is contained in the Regulations to the Act.

(a) Possession of a Narcotic

The Narcotic Control Act adopts the broad definition of "possession" found in the Criminal Code. Basically, in order to be convicted of possession, an accused must know the substance is illegal and have some control over it. Possession charges can be laid in three different kinds of situations.

The simplest cases are those in which the police find a narcotic in an accused's physical possession. This situation would arise if the accused was caught smoking a joint or if it was found on his person.

Secondly, an individual may be convicted of possession for having control over a narcotic which is in another place or within another person's physical possession. Assume that an accused hid some marijuana in a box of books which was stored at a friend's apartment. Assume as well, that the accused told his friend about the marijuana but not the friend's room-mate. If the police found the marijuana, the accused could be convicted of possession because he had control of the drug, even though it was not in his actual possession. The accused's friend could also be convicted because he knowingly possessed the marijuana. However, the room-mate could not be convicted, as he did not know the box contained an illegal drug.

The third type of situation is the most complex. Drugs found in the possession of one member of a group are considered, for legal purposes, to be in the possession of the other members if they are aware of the possession and consent to it. Generally, the courts require the prosecutor to prove that the other group members had knowledge of and some control over the illegal drugs. Thus a person would not likely be found in possession simply because he was at a party where others were smoking marijuana or because he walked down the street with someone who had a joint in his pocket. The result might well be different if an accused permitted a friend to smoke a joint in his car. As the owner, the accused has a legal right to control what happens in the car. The accused's failure to stop his friend provides a clear indication that he consented to the illegal possession.

Possession of any amount of a narcotic is unlawful and can result in a conviction. Consequently, ashes from a joint or the scrapings from a hash pipe will support a possession conviction. If the police seize a quantity of drugs that would not normally be used by only one person, the more serious charge of possession for the purpose of trafficking will be laid.

Possession of a narcotic is a dual procedure offence. If tried by summary conviction, the offence carries a maximum sentence of six months' imprisonment and a $1,000 fine for the first offence and of one year's imprisonment and a $2,000 fine for any subsequent offence. If, however, the prosecutor proceeds by indictment, the maximum penalty is seven years' imprisonment.

(b) Trafficking in a Narcotic

The NCA broadly defines the offence of trafficking to include manufacturing, selling, giving, administering, transporting, sending, delivering, or distributing a narcotic. An individual offering to do any of these things, even if he has no intention or ability to fulfill his promise, can also be charged with trafficking. No exchange of money is necessary; an individual who gives away or offers to give away any quantity of a narcotic may be convicted of trafficking. No distinction is drawn between a member of organized crime who sells kilograms of heroin and an individual who shares a single joint with a friend — both are trafficking. However, the drug involved, the quantity, and the offender's motive are factors that are usually considered in sentencing.

An individual who sells a substance which is not a narcotic, but which he claims to be a narcotic, may also be charged with trafficking. For example, a person who sells sugar to an undercover police officer claiming it to be heroin, can be convicted of trafficking.

Trafficking is an indictable offence which carries a maximum sentence of life imprisonment.

(c) Possession of a Narcotic for the Purpose of Trafficking

The police usually lay a possession charge when they seize a small quantity of drugs which they believe is for the suspect's own use. If, however, the police seize a quantity of drugs that would not normally be used by one person, they will generally lay a charge of possession of a narcotic for the purpose of trafficking. Even very small amounts of a narcotic along with evidence such as scales, bags, lists of names, a large amount of cash, or the accused's own statements, may provide sufficient grounds to charge an accused with possession for the purpose of trafficking. It is not necessary that the narcotic was intended for sale. Possession for the purpose of sharing constitutes possession for the purpose of trafficking.

Possession for the purpose of trafficking is an indictable offence which carries a maximum sentence of life imprisonment.

(d) Cultivation of Cannabis or Opium

Unless authorized by the government, it is a criminal offence to cultivate any amount of cannabis or opium. An accused may be convicted of cultivation whether he grows huge fields of cannabis or keeps a single plant. However, the prosecutor must first establish that the accused knew what the plant was and assisted in its growth. Cannabis grows wild in some parts of Canada, and a farmer who is unaware of cannabis plants growing on his land cannot be convicted.

Cultivation of cannabis or opium is an indictable offence which carries a maximum sentence of seven years' imprisonment.

(e) Importing or Exporting a Narcotic

These offences are among the most serious crimes in Canadian criminal law. A person may be charged with these

*This article is based on a chapter of a forthcoming book by the authors entitled, *Canadian Alcohol and Drug Laws*. The authors would like to thank the Law Foundation of Ontario and the Addiction Research Foundation of Ontario for their financial assistance during the preparation of the manuscript.

(from page 9)

offences for transporting any quantity of a narcotic across the Canadian border or for arranging to do so. The fact that the drugs were intended for the sole use of the importer or that the quantity was extremely small is no defence to an importing charge.

Importing and exporting are indictable offences and carry a mandatory minimum sentence of seven years' imprisonment and a maximum of life. Except for murder and high treason, no other crime carries as great a mandatory minimum penalty.

(f) Prescription Shopping

Although a number of narcotics used for medical purposes can be obtained by prescription, access to them is carefully controlled. The Regulations to the NCA make it an offence to get or attempt to get narcotics from one doctor, without disclosing that a prescription for narcotics had been obtained from another doctor within the previous 30 days. Prescription shopping or "double doctoring" is a summary conviction offence which carries a maximum penalty of a $500 fine and six months' imprisonment.

Section 4 — The Present Food and Drugs Act

As indicated, the FDA is primarily concerned with ensuring that foods, cosmetics, medicines, and medical devices are safe for human consumption or use. We will only be discussing a very small section of this complex Act, namely the two parts dealing with drugs that may be used for non-medical purposes and, the Regulations governing the unauthorized sale of prescription drugs.

(a) Part III of The Food and Drugs Act — Controlled Drugs

This part of the Act governs what are known as controlled drugs, which are defined as any drug listed in Schedule G. In addition to amphetamines and barbiturates, this Schedule includes about a dozen, less commonly used stimulants and depressants.

The Act contains only two offences for Schedule G drugs — trafficking and possession for the purpose of trafficking. Although there is no offence for possession, an individual found in possession of a large quantity of a Schedule G drug may be charged with possession for the purpose of trafficking. It should be noted that the definition of trafficking for controlled drugs differs from that used in the NCA.

In Part III, trafficking is defined as unauthorized manufacturing, selling, exporting, importing, transporting, or delivering. Unlike the NCA, the FDA definition of trafficking does not include "giving" or "administering." Moreover, the FDA does not contain separate offences for importing or exporting. Those engaged in this conduct are charged with trafficking.

Trafficking and possession of a controlled drug for the purpose of trafficking are dual procedure offences, punishable upon summary conviction by a maximum sentence of 18 months' imprisonment and upon indictment by a maximum of 10 years.

(b) Part IV of the Food and Drugs Act — Restricted Drugs

This part of the Act governs restricted drugs, which are defined as any drug listed in Schedule H. Pscilocybin, LSD (Lysergic acid diethylamide), DMT (Dimethyltriptamine), and MDA (Methylenedioxyamphetamine), are the most commonly used of the approximately 25 drugs in this Schedule.

There are three offences created for restricted drugs, namely possession, trafficking, and possession for the purpose of trafficking. This part of the Act adopts the Criminal Code's broad definition of possession that was discussed earlier. Possession of a restricted drug is a dual procedure offence. If the prosecutor proceeds by summary conviction, the maximum penalty is six months' imprisonment and a $1,000 fine for a first offence, and one year's imprisonment and a $2,000 fine for a subsequent offence. However, if the prosecutor proceeds by indictment the maximum sentence is three years' imprisonment and a $5,000 fine.

The definitions of trafficking and possession for the purpose of trafficking are the same for controlled and restricted drugs (see earlier discussion). Trafficking and possession for the purpose of trafficking in a restricted drug are dual procedure offences, punishable on summary conviction by up to 18 months' imprisonment and on indictment by up to 10 years' imprisonment.

(c) The Unauthorized Sale of Prescription Drugs

The FDA's Regulations contain very complex rules governing the manufacture, distribution, and sale of prescription drugs. Unless authorized by the Regulations, the sale of a prescription drug without the appropriate verbal or written prescription is not permitted. Any unauthorized sale constitutes a dual procedure federal offence. If tried by summary conviction, the maximum penalty is three months' imprisonment and a $500 fine for a first offence and six months' imprisonment and a $1,000 fine for a subsequent offence. If the prosecutor proceeds by indictment the maximum penalty is three years' imprisonment and a $5,000 fine.

Section 5 — The Impact of Discretion on the Federal Drug Laws

The preceding review of the NCA and the FDA may create an unduly harsh impression of the fate of drug offenders. As in many other areas of criminal justice, the severity of the law is lessened by the exercise of police officers', prosecutors', and judges' discretion. Those most likely to benefit from such discretion are young people with no previous criminal records. Such discretion is most likely to be exercised in cases involving the least serious offences, such as possession of marijuana.

For example, the police may take a young teenager found in possession of a joint home to be dealt with by his parents, rather than laying a criminal charge. Similarly, possession charges may be laid against only one occupant of a car, even though other occupants might also have been charged. Federal drug prosecutors usually lay possession for the purpose of trafficking charges against those caught bringing small quantities of cannabis across the border. By exercising their discretion not to lay importing charges, prosecutors protect such smugglers from a mandatory minimum sentence of seven years' imprisonment. Although possession of cannabis is a dual procedure offence, prosecutors rarely proceed by indictment. Judges rarely impose the maximum sentences or anything close to them in cannabis cases. As indicated, even a first-time cannabis possession offender can be sentenced for up to six months' imprisonment. Yet in 1981, only 5.2% of cannabis offenders were sentenced to imprisonment, and the vast majority of these sentences were for less than one month.

Nevertheless, it should be remembered that the accused has no control over whether the police, prosecutor, or judge will exercise their discretion. The fact that the police chose to warn one cannabis possession offender, does not prevent them from charging another person in the same circumstances. Similarly, merely because a lenient sentence was imposed in one case, does not mean that a lenient sentence will be imposed in a similar case.

The Narcotic Control Act: Offences, Definitions and Penalties

Offence	Definitions	Maximum Penalty
Possession	— to knowingly have a narcotic on your person — to knowingly control a narcotic in another place or within another person's possession — knowledge, consent and some control over a narcotic in the possession of a fellow group member	**Summary Conviction** — First Offence: 6 months & $1,000 fine — Subsequent Offence: 1 year & $2,000 fine **Indictment** — 7 years
Trafficking	— to manufacture, sell, give, administer, transport, send, deliver, or distribute any narcotic or substance held out to be a narcotic — to offer to do any of these things	**Indictment** — life
Possession for the Purpose of Trafficking	— to possess any narcotic for the above mentioned purposes	**Indictment** — life
Cultivation	— to knowingly grow or assist the growth of opium or cannabis	**Indictment** — 7 years
Importing or Exporting	— to knowingly transport or arrange for the transport of any narcotic across the Canadian border	**Indictment** — life (7 years mandatory minimum)
Prescription Shopping	— to obtain or attempt to obtain a narcotic from one doctor, without disclosing a prescription for a narcotic obtained from another doctor within the previous 30 days	**Summary Conviction** — 6 months & $500 fine

The Food and Drugs Act — Classifications, Offences, Definitions and Penalties

Classifications	Drugs in classification	Offences and definitions	Maximum penalty
Part III Controlled Drugs: Schedule G	amphetamines barbiturates (other stimulants and depressants)	**Trafficking** — to manufacture, sell, export, import, transport, or deliver any Schedule G drug or any substance held out to be a Schedule G drug	**Summary Conviction** — 18 months **Indictment** — 10 years
		Possession for the purpose of trafficking — to possess any Schedule G drug for the above mentioned purposes	
Part IV Restricted Drugs: Schedule H	LSD MDA DMT pscilocybin (other hallucinogenics)	**Possession** — to knowingly have a Schedule H drug on your person — to knowingly control a Schedule H drug in another place or within another person's possesion — knowledge, consent and some control over a Schedule H drug in the possession of a fellow group member	**Summary Conviction** — First offence: 6 months & $1,000 fine — subsequent offence: 1 year & $2,000 fine **Indictment** — 3 years & $5,000 fine
		Trafficking — see above	**Summary Conviction** — 18 months **Indictment** — ten years
		Possession for the purpose of trafficking — see above	
Prescription Drugs	Antibiotics Tranquillizers Birth Control Pills Pain killers (many other prescription drugs)	**Selling** — unauthorized sale of a prescription drug without the appropriate verbal or written prescription	**Summary Conviction** — First Offence: 3 months & $500 fine — Subsequent Offence: 6 months & $1,000 fine **Indictment** — 3 years & $5,000 fine

NEWS

Peers help govern consumption behavior

Drinkers keep pace with each other

By Heather Walker

SEATTLE — Drinking with a fast-drinking companion will make even a light or moderate drinker drink more heavily, suggest studies at the University of Washington here.

Alan Marlatt, PhD, described his research on social drinking at the National Research Conference on Women and Alcohol. In studies of peer influence on drinking behavior, "one subject was programmed to drink at a heavy rate to see if the other would drink at approximately the same rate to keep pace.

"We found that when with a heavy drinker, the partner would drink significantly more than with a light drinker or if alone."

Dr Marlatt found the opposite effect also held true — a light drinking model caused even normally heavy drinkers to drink less.

So far, Dr Marlatt said, his studies have only included drinkers of the same sex, but "I hope to look at the effect of heavy drinking men on women drinking partners soon."

Dr Marlatt referred to earlier studies which indicated that individual reactions to alcohol are based on expectation as much as or more than on the actual effects of the alcohol. In studies, participants were asked what effects they expected from alcohol, then given either an alcoholic drink or a placebo of straight tonic instead of vodka and tonic.

"The studies looked at men and women and examined whether anxiety was reduced in a threatening situation," he said. "The men were asked to create a good impression on an attractive woman without talking. Their anxiety was reduced if they expected to have alcohol in the drink. Their heart rates went down, and there were other signs of lowered anxiety. If they expected there was no alcohol in the drink, they remained more anxious.

"With women, there was the same situation, but the reverse effect — that is, their anxiety increased if they were expecting to receive alcohol."

Other studies showed that men who expected alcohol and were put in sexually-stimulating situations both reported to researchers that they were feeling aroused, and were physiologically more aroused than men who believed they had not drunk alcohol.

But women showed a different pattern. Like the men, those who expected alcohol told researchers they were aroused when shown pornographic material. However, those who actually had an alcoholic drink "showed not an expectancy result but an alcohol effect," Dr Marlatt said.

"According to their self-reports, they were feeling more aroused, but according to tests of things like vaginal blood flow they were actually less aroused than women who had not had alcohol. The alcohol caused a decreased physical effect, but their self-reports were the opposite."

Marlatt: creating an impression

Skid row stressors change with times

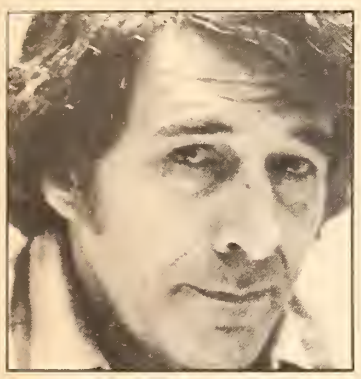
Fewer street people alcoholic

By Sissy Carpey

COATESVILLE, Penn — When Donald J. Ottenberg, MD, first began working with alcoholics 25 years ago in Philadelphia's skid row, the population was white, male, and, because there were many missions and cheap hotels, often able to find shelter.

Today's street people are different and have different stresses, Dr Ottenberg said here at the Veterans Administration conference on Stress: Alcohol and Drug Interactions.

"We've made interesting progress in 25 years," said Dr Ottenberg. "This group of homeless is racially integrated, where skid row was almost entirely white. Also. this population no longer suffers the effects of sexism. Twenty-five years ago you couldn't find a woman on skid row."



Ottenberg: many are 'fallouts'

Another difference, he pointed out, is that today's homeless range in age from the very young to the aged.

Discussing his work as medical consultant of a shelter for the homeless in Philadelphia, called SELF, Dr Ottenberg said many of today's homeless are "fallouts" — either of the mental health system which deinstitutionalized them or of recent changes in United States welfare rules.

Because highway construction and inner city revitalization destroyed old skid row missions and flop houses, today's homeless suffer more exposure to weather and isolation, Dr Ottenberg continued.

"I find it remarkable that people who live on the street can tolerate as much stress as they do. Often, they are paranoid about the people who try to help them. Many have their pride intact. On the coldest nights, the police have trouble just getting them to enter the vans to come to shelters so they don't risk dying on the streets."

Dr Ottenberg said that although there are many signs of mental illness, there appears to be no significant amount of depression. About 25% of today's homeless are alcoholics, as compared with 75% in the 1950s, he said.

But, "a lot of people drink when they can get alcohol. I think I would, too, if I lived on the street."

Most street people are isolated, although "occasionally, we will see a couple who are very close. In these cases, our job is more difficult because we can't even get them to leave each other to take a bath, to get deloused," he said.

He recommended more emergency shelters, immediate psychiatric and medical care, and protective environments to help people make the transition away from the street.

More study needed

Alcohol riskier for women?

By Heather Walker

SEATTLE — Women who are alcoholics appear to be facing greater health risks than their male counterparts, says a professor of psychiatry and psychology at the University of Pittsburgh School of Medicine.

"In general women drink less than men even when you take differences in body weight into consideration," Shirley Hill, PhD, said. "But there can be a greater risk to women," she told the National Research Conference on Women and Alcohol here.

She said although there are few studies comparing male and female alcoholics, a review of the evidence that is in shows they are equally or more vulnerable to drinking-related illnesses than are alcoholic men, and also probably have a higher mortality rate.

Women are more likely than men to develop complications such as fatty liver, hypertension, obesity, anemia, malnutrition, gastrointestinal hemorrhage, or ulcers, she said.

Common causes of death among alcoholic women are diseases of the digestive system — cirrhosis, pancreatitis, and other liver diseases — followed by accidents and violent death, cancer, and, finally, circulatory disorders.

Women appear to be particularly susceptible to liver diseases, she said. In a study of 293 alcoholics with cirrhosis, for example, 11% of the women, compared with 3% of the men, had the most severe form of the disease.

She suggested that the higher incidence of liver problems among women might be the result of a different drinking pattern. "Some studies have shown that women may be more likely to drink continuously, whereas men are more likely to binge, and the liver appears to be able to handle binge drinking better than continuous drinking," she said.

"The point is that it isn't only women in treatment centres who are at risk. People who drink as few as five drinks a day may be at risk of liver damage."

Dr Hill also referred to the possibility that women who drink might have a greater risk of breast cancer than those who abstain.

"There have been a couple of recent papers that said women who drink have 1.9 times more chance of getting breast cancer than those who abstain," she said.

Although that study has not been replicated, "the point is that more study is needed in this area.

"There appears to be an equal or greater risk of morbidity or mortality for women drinkers, and it is becoming clear that there needs to be more attention given to the investigation of women who drink moderately as well as those who drink heavily."

Paraquat debate waning in face of logic: Schuchard

ATLANTA — Many academics still consider drug use is a "pro-environmental" issue and somehow healthy, charges Keith Schuchard, PhD, a founder of the PRIDE parents organization in the United States.

She said this twisted logic leads to a campaign against spraying the herbicide paraquat on marijuana crops: "You are against chemicals outside, but it is OK inside."

Dr Schuchard told the annual conference of PRIDE (Parents' Resource Institute on Drug Education) here if the real environmental worry is paraquat, then the debate should be extended to use of the pesticide on tomato, potato, and soybean crops.

"Let's deal with the issue of paraquat head on and not just deal with it because it's being used on marijuana plants."

As for who is tampering with the environment, Dr Schuchard said marijuana growers "have bear traps, steel jaw traps, guns, and grenades to make sure when you are going into your national forest you don't come into their plot of land."

In the minds of some, she said, drug use is synonymous with "peace," yet drug trafficking has produced the most violent of all criminal networks. And, while others are concerned about environmental effects on the developing fetus," they ignore the fact drugs such as marijuana can cause genetic and cellular changes."

Schuchard: 'most violent of all'

Better psychosocial pattern correlated with abstinence Gaspé region study finds

MONTREAL — Clients who manage to abstain from alcohol seem to lead better lives afterwards than those who become controlled drinkers, says a McGill University psychiatrist.

"Abstinence has a significant correlation with the improvement of legal status, psychopathology, the subject's commitment to community activities, the effects on the family, and behavior at work and in society," says Maurice Dongier, MD, of the university's psychiatry department.

Dr Dongier says a study of 150 clients of the Centre l'Escale in Ste-Anne-des-Monts in the Gaspé region of Quebec showed a clearer link between abstinence (as opposed to controlled drinking) and "improved psychosocial behavior." He outlined these findings at the conference on Alcoholism and Other Drug Dependencies here.

Interviews with the clients took place from one to 11 years after rehabilitation with an average follow-up of six years. Spouses, other family members, or fellow employees were interviewed to corroborate the client's statements, he said.

The Gaspé study had similar results to other research done in North America, Dr Dongier said. However, he noted the sample study disregarded subjects who died or couldn't be reached and gave "an impression of a more optimistic picture than reality."

Nevertheless, this study and others show about two-thirds of the subjects were either abstaining or were better at the time of evaluation. Contrary to general pessimism (by intervening parties and physicians in particular), the majority of subjects appear to be considerably improved after treatment," he said.

Treatment of alcoholism is "profitable" because it reduces the future use and cost of medical care, Dr Dongier added.

"You're lucky! You're leaving because you can't stay up past 8 o'clock! I'm leaving because my dad's an alcoholic."

NEWS

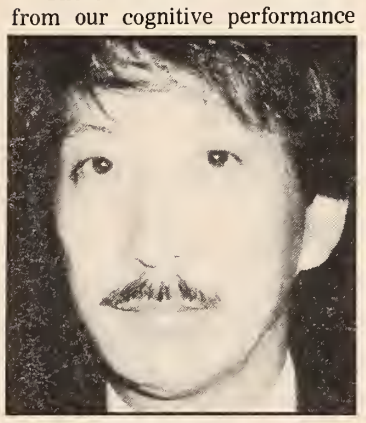
Lithium may cut alcohol's intoxicating effects

LOS ANGELES — The anti-manic drug lithium carbonate may have a valuable therapeutic role in the treatment of all chronic alcoholics, suggests a California study.

Leighton Huey, MD, and colleagues gave lithium to 35 detoxified alcoholic men in a study at the University of California, La Jolla. The researchers found lithium reduces the intoxicating effects of alcohol.

"Our patients felt less intoxicated when challenged with alcohol and had less desire to continue drinking while on lithium compared to placebo," said Dr Huey, associate professor of psychiatry, at the annual meeting here of the American Psychiatric Association.

"There is also some evidence from our cognitive performance data that lithium may attenuate or modify alcohol-induced disruption of cognitive performance. Our patients reported feeling less confusion from the same dose of alcohol while on lithium versus placebo."



Huey: mood important

The behavioral mechanism by which lithium may exert a beneficial effect in alcoholics is by preserving intact congnitive functions during ethanol intoxication, such that the alcoholic is better able to control his drinking behavior, he said.

In contrast to an earlier study by other investigators, who found lithium useful only in depressed alcoholics, Dr Huey's group found mood to be an unimportant factor in determining benefit from lithium treatment. Also unimportant were a family history of alcoholism and whether the patient has primary or secondary alcoholism.

As a result, Dr Huey said he does not believe lithium's benefit in controlling an alcoholic's drinking behavior is based on the drug's ability to stabilize mood and affect. A possible alternative explanation of lithium's effect on the subjective experience of alcohol intoxication is that it specifically blocks or otherwise alters the nerve pathways involved in producing an alcoholic high.

"It is also possible that ethanol's effect in the presence of lithium is significantly different from that of ethanol alone, and that difference is easily discernible to the alcoholic who has a great deal of personal experience with ethanol intoxication," Dr Huey said.

"In other words, ethanol consumed while on lithium may produce a different and less familiar subjective experience for the alcoholic. He feels less intoxicated and less inclined to continue drinking."

The 35 patients studied by Dr Huey and associates ranged in age from 24 to 55 years, with the average age in the group being 40. They were detoxified from alcohol for a minimum of 21 days before participating; 16 were diagnosed as having a psychiatric disorder in addition to alcoholism.

The patients were randomly assigned to receive either lithium or placebo for 14 days. At the end of this period, patients on lithium were switched to placebo and vice versa for a further two weeks. In both phases of the study, the patients were given a variety of self-rating scales and a battery of cognitive tests before and after challenge with a standard intoxicating dose of 95% ethanol given in orange juice. An equivalent form of the cognitive tests was used after alcohol challenge to minimize the effects of practice.

Dr Huey said the blood alcohol levels were the same on lithium and on placebo. The average serum lithium levels were within the accepted therapeutic range.

Until further and larger controlled studies are carried out, Dr Huey cautioned against "haphazard use" of lithium in alcoholic patients since long-term use of lithium is associated with adverse side effects.

Further study should clarify the benefits and risks of lithium therapy in alcoholics, he said.

Good news on coffee for heart patients

CARMEL, Cal — Cardiovascular specialists may have good news about coffee drinking for some patients, following presentation of a study here.

Coffee consumption appears to delay the onset of pain caused by exercise in patients with ischemic heart disease, says a study done at the Long Beach Veterans Administration Medical Center, Long Beach, California.

Kenneth Piters, MD, staff cardiologist, presented the results at the annual meeting of the Western Federation for Clinical Research.

Seventeen males with an average age of 59 years, all of whom had coronary artery disease and were chronic coffee users, were given treadmill stress tests over three consecutive days.

In a random sequence the patients were given two cups of decaffeinated coffee, one cup of coffee with caffeine and one cup decaffeinated, or two cups of coffee with caffeine on each day.

Stress tests were performed both before and after the coffee was consumed, and the patients exercised until they felt the amount of pain that usually limited their exercise.

Dr Piters said that after drinking one cup of caffeine coffee, the patients were able to exercise an average of 8% longer; after two cups, this average rose to 12%.

Heart rates or blood pressure readings did not differ significantly because of caffeine consumption.

Dr Piters concluded "the lack of deleterious effects upon exercise-induced angina from drinking a moderate amount of coffee in patients with ischemic heart disease is reassuring."

He said that while physicians should still exercise judgement in advising individual patients about coffee consumption, they may feel more comfortable with the knowledge that, as the study implies, exercise-induced angina will not be particularly exacerbated by drinking coffee.

Supplies are drying up of illicit methaqualone

WASHINGTON — Sales of illegally produced methaqualone (Quaaludes) have almost disappeared in the United States because of international cooperation and operations.

Gene Haislip, deputy assistant administrator of the US Drug Enforcement Administration (DEA) said the number of illegal methaqualone tablets in circulation has dropped from a high of some 500 million in 1980 to virtually none today (The Journal, April).

Agency officials in Florida, where most of the illegal methaqualone enters the US from labs in Colombia, said agents seized nearly 16 million tablets in 1980, some 700,000 last year, and only 34 so far in 1984.

Mr Haislip said the DEA worked with Colombian authorities to track down both the legal routes by which the methaqualone powder was brought in to Colombia, and the undercover labs which processed the powder into tablets.

Haislip: international cooperation stopped the flow

Countries where the powder is manufactured legally have cooperated in shutting off the supply to traffickers, who would buy in lots as high as nine tons at a time.

Students vie for top DWI ditty

VANCOUVER — Lower Mainland high school students here are competing for a stereo package for the best song on the hazards of drinking and driving.

The contest was launched by the Drinking Driving Counterattack Committee (DDCC) in conjunction with two stereo retailers, the Insurance Corporation of British Columbia, and the Columbia Academy of Recording Arts.

Students must compose a song directly related to the DDCC program, emphasizing the dangers of drinking and driving. Submissions will be judged on originality, style, musical expression, composition, and technique, as well as how successfully the message is expressed.

Vancouver DDCC president Pat Roberge says the contest was conceived to provide students with direct involvement in the anti-drinking-driving battle. The successful entry will be recorded in a professional studio.

Act shifts responsibility to teens

Youth law change will hit workers, parents

TORONTO — The Young Offenders Act (YOA), which went into effect in April, will have implications not only for young people themselves but for professionals who deal with them.

This is the advice of Merlyn Green, program coordinator, Residential Services Unit, Ontario ministry of community and social services.

The philosophy of the Act is to "make young people more accountable for their actions," he told workers at the Addiction Research Foundation here.

While this would not necessarily have an impact on what counsellors and treatment workers do or how they do it, he cautioned that awareness of the change may be key to dealing with young people in trouble with the law.

The YOA "applies the adult Criminal Code to young people," Mr Green said. The penalties are different from those imposed on adults, but young people will, nonetheless, be expected to bear the responsibility, he said.

Parents, too, will experience a shift following the passage of this legislation. While the Act takes away the vicarious liability of parents for the criminal actions of their teenagers (young people not parents will be responsible for paying fines, serving community work orders, and making restitution or compensation to the victims) parents will be more involved in the court process.

"By the very nature of encouraging parents to be involved in the court process, they are also encouraging parents to remain involved with their kids," Mr Green told **The Journal**.

"Gone is the concept of wardship," where the state takes over responsibility for the child, he said.

"The YOA leaves the responsibility of parenting with the parents.

"It will not absolve them and say, 'Oh, you are bad parents, we'll do the parenting from the state.' "

In addition to understanding the philosophical shift, treatment workers and counsellors will also have to work within clearly set parameters and definite time periods when dealing with young offenders, Mr Green said.

The YOA calls for specific sentences for young people who have committed an offence. Under the Juvenile Delinquents Act, they were given an indefinite, "open-ended" sentence or probation and treatment or education professionals "could work with the young people until you felt they had gained all the benefit they were going to," Mr Green said. The length of stay in an institution was determined by the young person's behavior; now it is predetermined by the court.

"It is too early to say" whether this will affect attitudes of those ordered to attend treatment or education programs, he said.

"I wouldn't want to say categorically that some of the kids come in with the attitude that — 'well, I'll just do my time' — but it could be a problem."

And, Mr Green said, strict provisions in the Act concerning confidentiality and record keeping could have implications in the field. Records relating to criminal charges or court appearances must be destroyed after a set period of time. Failure to do so can result in charges being laid against the record keepers.

Treatment and assessment reports would fall under this rule as well, Mr Green said. He suggested that any such references be separate from a general report so that they may be destroyed more easily.

Room, Mäkela share 1983 Jellinek award

ATHENS — Robin Room, of the Alcohol Research Group, Berkeley, California, and Dr Klaus Mäkela, research director of the Finnish Foundation for Alcohol Studies, received the Jellinek Memorial Award for 1983. The two researchers were selected for their "contributions to the comparative study of alcohol control policies, and for epidemiological research on the relationship between population drinking and drinking problems." The presentation was made at the International Council on Alcohol and Addictions meeting here, recently.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000 ext 7384.

Misleading Cases

Number: 573.
Subject heading: Attitudes and values, professional training.
Details: 12 min, color.
Synopsis: A professor of medicine is drinking in the faculty club before delivering his lecture. When he enters the lecture hall, he insults the students and then proceeds to illustrate diagnostic techniques. He stereotypes each case: one man is obese "because he eats too much pasta;" one has black eyes "because that kind fights a lot;" a woman needs hormone pills "because she is a woman," etc. In each case the real daily life of the person in question is shown. Each is a problem drinker and this diagnosis has been completely missed by the professor, who returns to the faculty club, has a few more drinks and is stopped for impaired driving as he leaves.
General evaluation: Good to very good (4.7). This humorous, contemporary, well-produced film made its point very well.
Recommended use: Professional training for all health and social workers.

Marijuana and Your Mind

Number: 609.
Subject heading: Cannabis.
Details: Two filmstrips plus cassettes — 10 min each.
Synopsis: These filmstrips discuss the history of research on the effects of marijuana; recent findings indicate marijuana is more hazardous than was believed 10 years ago. Implications for driving are also discussed.
General evaluation: Fair (3.3). Although the review group had concerns about the accuracy of some statements made about the effects of marijuana, the filmstrips were judged to be restrained in their viewpoint and potentially-useful teaching aids.
Recommended use: With a resource person to correct the doubtful statements, these filmstrips could benefit audiences 12 to 18 years of age.

A Better Place — A Better Time

Number: 610.
Subject heading: Drugs and youth, training.
Details: 28 min, 16 mm, color.
Synopsis: Samantha, a high school student, is practising for a piano recital. She asks a friend to give her some pot to help her relax and get through this important event. Another student has been suspended from school for drinking in the parking lot and being abusive to a teacher. A guidance counsellor would like to help both students. However, the vice-principal considers the drinking student only as a discipline problem, and Samantha's music teacher does not want any interference in her relationship with Samantha. The counsellor persists and, with the help of a probation officer, persuades the vice-principal to support working with the drinking student, but Samantha's problem is left unresolved.
General evaluation: Very good (5.0). This contemporary, well-produced film was judged to be a good teaching aid. General broadcast was recommended.
Recommended use: With a resource person, would be of benefit to educators at all levels.

DEPARTMENT

New Books by RON HALL

Booze

. . . by James R. Sallows

The search for effective alcohol education programming has resulted in the emergence of an approach that is new in the drug education literature. The content of these programs does not appear to be different, but what has changed is the medium of the message — live theatrical performances. Since *Booze* presentations have been met with widespread enthusiastic response from high school students, and because the evaluations support the play's effectiveness as an educational tool, the script and production notes have been made available to the public. The notes are designed to encourage novice directors to take up the challenge of producing this play. The belief is that with these notes, health educators themselves may develop an alcohol education program that can be presented to a whole school population. The show runs approximately 60 minutes and consists of six separate vignettes which can be performed as individual pieces, or presented in sequence as a complete show. The Director's Copy provides information on the script, dialogue, rehearsal schedule, performance setting, rehearsal process, casting and auditions, drunkenness, scene work and characterization, props and costumes, lights and sound, and other performance aspects. A package consists of a Director's Copy with production notes and 10 scripts.

Addiction Research Foundation, Marketing Services, Dept JR, 33 Russell St, Toronto, ON M5S 2S1, 1984. Package $20. ISBN 0-88868-085-6)

Identifying and Measuring Alcoholic Personality Characteristics

. . . edited by W. Miles Cox

This book presents a point of view on how personality factors are involved in alcoholism. The first chapter deals with methodologies that have identified distinctive personality characteristics of alcoholics before the onset of alcoholism. What happens when a person drinks alcohol after he or she has become alcoholic is the topic of chapter two. Next is a description of perceived control as one personality variable that pervades the lives of alcoholics. The remaining three chapters are concerned with ways in which alcoholics can be grouped to eliminate the distortions created by the view that alcoholics form a single homogenous group with respect to their personality characteristics. The conclusion reached is that there seems to be not one alcoholic personality, but several which can be understood best in terms of their interaction with other variables that help to explain alcoholism.

(Jossey-Bass, Publishers, Dept 62425, PO Box 62000, San Francisco, CA 94162, 1983. 107 p. $7.95. ISBN 87589-964-1)

Drug Trafficking: A North-South Perspective

. . .by Andre McNicoll

This study attempts to put the phenomenon of the South-North drug trade into perspective. The material is organized around a discussion of the three narcotic drugs that dominate illicit trade: opium and its derivatives, cocaine, and the derivatives of cannabis. Each of the three drugs is studied in relation to its impact on particular countries or regions of the world. There is also a discussion of an increasingly important change taking place in the drug trade: the illicit flow of psychotropics from the industrialized countries to the Third World. The first chapter situates in an historical context the several antecedents that have shaped present trafficking patterns. The second summarizes the socio-economic parameters that govern the cultivation, trade, and use of illicit narcotics. The final chapter looks at the options to law enforcement measures which are being pursued in major narcotics-producing regions.

(North-South Institute, 185 Rideau, Ottawa, ON K1N 5X8, 1983. 94p. $6. ISBN 0-920494-39-0)

Other books

The Little Black Pill Book — Chilnick, Lawrence D. (ed). Bantam Books, New York, 1983. Pill abuse in the 1980s; 10 myths of drug abuse; physical side of abuse; drugs and lifestyle; how to identify a drug problem; getting help; pills and the law; look-alikes; profile of commonly prescribed drugs and their effects; Tables. Index. 272 p. Bantam Books, 666 5th Ave, New York, NY 10103. $3.95. ISBN 0-553-23786-1.

Drugs, Driving and Traffic Safety — Willette, Robert E. and Walsh, J. Michael (eds). World Health Organization, Geneva, 1983. Epidemiology; effects of drugs on driving performance; role of public health authorities; international collaboration and future approaches to the problem; references. 57 p. Canadian Public Health Association, 1335 Carling Ave, Ste 210, Ottawa, ON K1Z 8N8. ISBN 92-4-170078-5.

Directory of Alcohol and Drug Treatment Resources in Ontario 1984 — Blake, Catherine (ed). Addiction Research Foundation Addiction-specific and general resources; alphabetical program listing; detailed geographic listing; indexed by type of treatment, services for special populations, and special focus. 434 p. Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1. $29.95. ISBN 0-88868-087-2.

Eating Right to Live Sober — Ketcham, Katherine and Mueller, L. Ann. Madrona Publishers, Seattle, 1983. Alcoholism; malnourished alcoholic; hypoglycemia; controversies; the diet; taking drugs in crises; vitamin dosages for alcoholics; references. Index. 361 p. Madrona Publishers, PO Box 22667, Seattle, WA 98122. $17.95. ISBN 0-914842-97-8.

Psychosocial Constructs of Alcoholism and Substance Abuse — Stimmel, Barry (ed). Haworth Press, New York, 1983. Dependency on mood-altering drugs; alcohol problems and depressive symptoms; anti-social opiate addict; alcohol and sexual functioning; family in the etiology and treatment of drug abuse; chronological maturation and treatment of drug abuse. 110 p. Haworth Press, 28 E 22 St, New York, NY 10010. $14.95. ISBN 0-86656-244-3.

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Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Management for Supervisors in the Health Care Setting — July 5-6, Aug 16-17, Toronto, Ontario, July 3-4, Edmonton, Alberta, Aug 13-14, Halifax, Nova Scotia. Information: Ingrid Norrish, Program Manager, Professional and Management Development, Humber College, Box 1900, Rexdale, Ontario M9W 5L7.

26th Annual Scientific Assembly of The College of Family Physicians of Canada — July 8-11, Vancouver, British Columbia. Information: The College of Family Physicians of Canada, 400 Leslie St, Willowdale, ON M2K 2R9.

Medico-Legal Problems in Practice — July 9-14, Toronto, Ontario. Information: School of Continuing Studies, 158 St George St, Toronto, ON M5S 2V8.

Therapeutic Trends in the 80s — July 11-13, Montebello, Quebec. Information: Carol Zaman, Postgraduate Board, The Montreal General Hospital, 1650 Cedar Ave, Montreal, Quebec H3G 1A4.

25th Annual Institute on Addiction Studies — July 15-20, Hamilton, Ontario. Information: Karl N. Burden, Course Director, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

Summer Fundamental Concepts Course — July 16-19, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation (ARF), 8 May St, Toronto, ON M4W 2Y1.

Medical Women's International Association 60th Congress: Men and Women, Biological and Behavioral Differences — July 29-Aug 4, Vancouver, British Columbia. Information: Congress Secretariat, Medical Women's International Association, #1704-1200 Alberni St, Vancouver, BC V6E 1A6.

Canadian Society of Forensic Science 31st Annual Conference —Aug 18-24, Winnipeg, Manitoba. Information: Executive Secretary, Canadian Society of Forensic Science, 171 Nepean St, Ste 303, Ottawa, Ontario K2P 0B4.

1984 Annual Convention of the American Psychological Association — Aug 24-28, Toronto, Ontario. Information: American Psychological Association, 1200 17th St, NW, Washington, DC 20036.

University of Toronto Department of Psychiatry 10th Annual Research Day — Sept 21, Toronto, Ontario. Information: K. Drysdale, Secretary, Research Fund Committee, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Detox Training Programs (nonmedical) — Sept 24-28, Oct 22-26, Nov 19-23, Toronto, Ontario. Information: Diane Hobbs, Coordinator of Detox and Rehabilitation Programs, ARF, 33 Russell St, Toronto, ON M5S 2S1.

Workplace 84 "Making the Most of Human Potential" — An Employee Assistance Programming Conference — Oct 15-17, Grande Prairie, Alberta. Information: Iyas Abbas, Alberta Alcoholism and Drug Abuse Commission, Provincial Building, Rm 2204, 10320 99 St, Grande Prairie, AB T8V 6J4.

5th Annual Meeting Canadian Group Psychotherapy Association — Oct 17-20, Ottawa, Ontario. Information: Edgardo Perez, MD, department of Psychiatry, Civic Parkdale Clinic, 3rd fl, Ottawa Civic Hospital, 737 Parkdale Ave, Ottawa, ON K1Y 4E9.

22nd Annual Scientific and Business Meeting — Oct 17-20, Toronto, Ontario. Information: Lyn Robinson, Chairman, 1984 Convention Committee, Ontario Chapter College of Family Physicians of Canada, 4000 Leslie St, Willowdale, ON M2K 2R9.

Event 84 Skills Development Training Programs for Employee Assistance Personnel — Oct 28-Nov 1, Oakville, Ontario. Information: James Simon and Jaan Schaer, United Employee Assistance Councils of Ontario, Port Credit PO, Box 253, Mississauga, ON L5G 4L8.

Chemical Abuse and Your Employee — Nov 28 and Jan 23, 1985, Toronto, Ontario. Information: Yvonne Johns, department head, Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

What Every Employer Needs to Know — Feb 20-22, 1985, Toronto, Ontario. Information: Yvonne Johns, department head, Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-9, 1985, Calgary, Alberta. Information: Jan Skirrow, Chairman, 34th ICAA Congress, AADAC, 6th fl, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

United States

Union College Conference: Genetics and the Human Encounter With Alcohol — July 6-7, Schenectady, New York. Information: Office of Graduate and Continuing Studies, Union College, 1 Union Ave, Schenectady, NY 12308.

Group Facilitator Skills — July 9-13, Milwaukee, Wisconsin. Information: Candee Brandis, Training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

13th Annual San Diego Summer Alcohol and Drug Studies Program — July 9-13, La Jolla, California. Information: Melanie Robertson, UCSD Extension, X-001, University of California, San Diego/La Jolla, CA 92093.

Fundamentals of Group Counselling — July 11-13, Center City, Minnesota. Information: Martha Harding, Hazelden Training and Professional Education, Box 11, Pleasant Valley Rd, Center City, MN 55012.

Program in Human Sexuality — July 15-20, Marine-on-St-Croix, Minnesota. Information: Coordinator, CDFI Summer Institute, Program in Human Sexuality, University of Minnesota, 2630 University Ave SE, Minneapolis, MN 55414.

17th Annual Institute of Alcohol Studies — July 22, Austin, Texas. Information: Laura Burns, Texas Commission on Alcoholism, 1705 Guadalupe, Austin, TX 78701.

Student Assistance Programming — July 23-27, Milwaukee, Wisconsin. Information: Candee Brandis, Training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

New York Federation of Alcoholism Counselors 5th Annual State Conference — July 25-29, Long Island, New York. Information: Barbara Maurer, NYFAC, 1271 Boston Ave, Bay Shore, NY 11706.

"Healing Adult Children of Alcoholics", "Laughter, Creativity and Play" — July 27-29, Bloomington, Minnesota. Information: Children Are People, Inc, 1599 Selby Ave, St Paul, Minnesota 55104.

Chemical Dependency Issues with the Impaired Health Professional and the Family — July 28-29, San Francisco, California. Information: Stephanie Ross, Haight Ashbury Training and Education Projects, 409 Clayton St, San Francisco, CA 94117.

Current Issues in Cocaine, Alcohol, PCP and Opiate Treatment — July 30, San Francisco, California. Information: Stephanie Ross, Haight Ashbury Training and Education Projects, 409 Clayton St, San Francisco, CA 94117.

The Alcoholism Relapse Problem — Theory, Prevention, and Practical Guidelines for Treatment — Aug 2-3, Amityville, New York. Information: Herbert Martey, Director of The Institute of Alcohol Studies at South Oaks, 400 Sunrise Hwy, Amityville, LI, NY 11701.

An Adult Child Weekend — Aug 4-5, Indianapolis, Indiana. Information: ACCESS . . . Alcoholism Counselor's Continuing Education Services, 3901 Meadows Dr, Ste B-1, Indianapolis, Indiana 46205.

National Association of Alcoholism and Drug Abuse Counselor's Annual Conference — Aug 4-8, Indianapolis, Indiana. Information: NAADAC, 951 S George Mason Dr, Arlington, Virginia 22204.

13th Annual Summer Session, Oregon Institute of Alcoholism Studies — Aug 5-10, Salem, Oregon. Information: Ruthanne Lidman, Coordinator, OIAS, PO Box 1240, Waldport, OR 97394.

New Jersey Summer School of Alcohol and Drug Abuse Studies — Aug 5-10, New Brunswick, New Jersey. Information: Summer School of Alcohol Studies, Rutgers University, New Brunswick, NJ 08903.

The Substance Abuse, Juvenile Justice, Human Services Annual Summer School — Aug 6-10, Iowa City, Iowa. Information: D. Terry Rawls, Training Manager, Iowa department of Substance Abuse, Ste 202, Insurance Exchange Building, 505 5th Ave, Des Moines, IA 50319.

The International Doctors in Alcoholics Anonymous Annual Meeting — Aug 9-12, Minneapolis, Minnesota. Information: Lewis Reed, MD, Information Secretary, IDAA, 1950 Volney Rd, Youngstown, Ohio 44511.

North American Congress on Employee Assistance Programs — Aug 12-15, Dearborn, Michigan. Information: Diane Vella, Congress Coordinator, NAC/EAP, 2145 Crooks Rd, Ste 103, Troy, MI 48084.

7th Annual School for Alcohol and Drug Studies — Aug 12-17, Wilmington, North Carolina. Information: North Carolina School for Alcohol and Drug Studies, Office of Special Programs, UNC-Wilmington, 601 S College Rd, Wilmington, NC 28403-3297.

2nd Annual Institute in the Management of Substance Abuse Services: The Clinician to Manager Transition — Aug 14-16, Cambridge, Massachusetts. Information: Barry Sugarman, PhD, Lesley College Graduate School, 29 Everett St, Cambridge, MA 02238.

Alcohol and Drug Problems Association (ADPA) 35th Annual Conference — Aug 19-23, Washington, DC. Information: Eric Scharf, Alcohol and Drug Problems Association, 1101 15th St, NW, #204, Washington, DC 20005.

16th Annual Nevada Substance Abuse School — Aug 20-24, Las Vegas, Nevada. Information: Angela L. Alaimo, Bureau of Alcohol and Drug Abuse, 505 E King St, 5th fl, Carson City, NV 89710.

Chemical Dependency and the Older Adult: Expanding the Network — Aug 22, Saint Paul, Minnesota. Information: Bobbie Walker, Bridgeway Center, 22-27th Ave SE, Minneapolis, MN 55414.

Colorado West Regional Mental Health Center, 4th Annual National Conference on Marketing Mental Health Services and Employee Assistance Programs — Sept 30-Oct 2, Breckenridge, Colorado. Information: Laurie Loeb, CWRMHC, Administrative Office, PO Box 40, Glenwood Springs, CO 81602.

Alcohol and Drug Problems Association (ADPA) Northwestern Regional Conference — Oct 7-9, Seattle, Washington. Information: Eric Scharf, Alcohol and Drug Problems Association, 1101 15th St, NW, #204, Washington, DC 20005.

American Association for Marriage and Family Therapy 42nd Annual Conference — Oct 18-21, San Francisco, California. Information: AAMFT Conference Committee, 1717 K St, NW, Ste 407, Washington, DC 20006.

1984 Postgraduate Course in Clinical Pharmacology, Drug Development, and Regulation — Oct 22-Oct 26, Rochester, New York. Information: Kristine Niven, Administrator, Center for the Study of Drug Development, The University of Rochester Medical Center, 601 Elmwood Ave, Rochester, NY 14642.

18th Annual Association for the Advancement of Behavior Therapy (AABT) Convention — Nov 1-4, Philadelphia, Pennsylvania. Information: John E. Martin, PhD, Program Chairperson, AABT/84, Psychology (116B), VA Medical Center, Jackson, Mississippi 39216.

4th Annual Fall Conference on Alcoholism — Nov 7-9, Williamsburg, Virginia. Information: Craig Nuckles, director, Riverside Hospital Alcoholism Treatment Program, J. Clyde Morris Blvd, Newport News, VA.

2nd National Conference on Alcohol and Drug Abuse Programming for Colleges and Universities — Nov 11-14, Boston, Massachusetts. Information: Eric Scharf, Alcohol and Drug Problems Association, 1101 15th St, NW, #204, Washington, DC 20005.

Abroad

3rd Biennial AU School of Justice, Institute on Juvenile Justice —July 8-July 27, London, England. Information: Prof Richard A. Myren, Director, Institute on Juvenile Justice in England and America, School of Justice, The American University, Washington, DC 20016.

Royal College of Psychiatrists: Annual Meeting — July 10-12, Cardiff, Wales. Information: College Secretary, 17 Belgrave Square, London SWIX 8PG, UK.

International Narcotic Research Conference — July 22-27, Cambridge, England. Information: Mrs Linda Byford, Parke Davis Research Unit, Addenbrookes Hospital Site, Cambridge CB2 2QB UK.

International Conference on Alcoholism and Other Drug Abuse — Aug 12-15, Lima, Peru. Information: Mary Vasquez, PhD, VMC, Employee Assistance Programs, 38760 Northwoods Dr, Wadsworth, Illinois 60083.

3rd International Conference on Treatment of Addictive Behaviors — Aug 12-16, North Berwick (Edinburgh), Scotland. Information: William R. Miller, PhD, department of Psychology, University of New Mexico, Albuquerque, New Mexico 87131.

5th World Congress on Prevention — Aug 26-30, Rio de Janeiro, Brazil. Information: Ernest H. J. Steed, Executive Director, International Commission for the Prevention of Alcoholism and Drug Dependency, 6830 Laurel St, NW, Washington DC 20012.

8th World Conference of Therapeutic Communities — Sept 2-7, Rome, Italy. Information: Charles J. Devlin, Executive Director, Daytop Village Inc, 54 W 40th St, New York, NY 10018.

Seminar on Addiction — Sept 6-14, Athens, Greece. Information: Darcy Edwards, Millglen Medical Corp, PO Box 888673, Atlanta, Georgia 30356-0673.

International Congress on Alcohol Dependence, The Family and The Community — Sept 16-22, Jerusalem, Israel. Information: International Congress on Alcohol Dependence, the Family and the Community, Kenness International Inc, 1 Park Ave, New York, NY 10017.

11th International Conference of Social Gerontology — Oct 16-19, Rome, Italy. Information: International Center of Social Gerontology, 91, rue Jouffroy, 75017 Paris, France.

1984 World Congress of Acupuncture and Natural Medicines — Oct 19-24, Colombo, Sri Lanka. Information: Prof Dr Anton Jayasuriya, Secretary-General, Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

"Addiction: A Hundred Years On" Centennial Symposium — Oct 25-26, London, England. Information: The Royal Society, 6 Carlton House Terrace, London SWI, England.

2nd Inter-American Symposium on Health Education — Nov 4-9, Acapulco, Mexico. Information: Symposium Steering Committee, c/o NARO, PO Box 2305, Stn D, Ottawa, Ontario, K1P 5K0.

Prophylactics of Drug Abuse — Dec 10-12, Warsaw, Poland. Information: Secretariat of the Symposium, Society for Prevention of Drug Abuse, Aleje Ujazdowskie 22, 00-478 Warsaw, Poland.

12th International Conference on Health Education — Sept 1-6, 1985, Dublin, Ireland. Information: Dr H. D. Crawley, Director, Health Education Bureau, 34 Upper Mount St, Dublin, Ireland.

'Most municipalities are bereft of a functional, dynamic policy'

Ontario community tackles public drinking

By Jon Newton

Thunder Bay is a northern Ontario city of about 120,000 people, on the shores of Lake Superior. It has some of Canada's lushest country and is a popular vacation spot.

Two years ago citizens and visitors could drink in their tents or trailers in municipal campgrounds at the city's Chippewa Park, or within a limited radius of their temporary homes. And they did.

On the holiday weekend of July 1, 1982, however, the partying got out of hand.

Picnic tables were set on fire, police couldn't get near the offenders because they were hurling rocks, and nearly 100 liquor violation tickets were issued.

The party cost Thunder Bay a small fortune in clean-up fees, but the price was far higher in terms of disruptions to the community, and arrests for crimes and offences involving alcohol.

Concern had started to crystallize in 1976 when a child was accidentally struck by a chair during a party in a municipally-owned golf club. It was a forceful reminder to city administrators that they had no effective approach to alcohol-related problems.

For four years the subject was debated and argued, then in 1980 an official policy was adopted. It aimed at handling the problem of alcohol abuse in municipal facilities without infringing on the rights of individuals in the community. But it wasn't enough.

And, when city officials started looking for data on alcohol management in municipal societies, they found they had nowhere to turn but to their own resources. Thunder Bay was not alone in lacking an effective solution to the problem of alcohol. In a sample of 30 other communities, none had a policy. Instead, they all relied on local, provincial, and federal rulings.

Moreover, as in Thunder Bay, the rules and regulations were designed to control problems as they occurred rather than prevent them in the first place. The job of coming up with a workable program fell five years ago to Marg Thomson, Thunder Bay's newly-appointed planning and policy developer.

Unequivocal views

Originally from Australia, she has unequivocal views on the subject of recreation and alcohol. As she explained recently, she came from a country where a community centre without beer is like a man without a soul. The Thunder Bay experience quickly changed her views.

Last month more than 140 people at a community-based workshop in Sudbury, Ontario, organized in conjunction with the Addiction Research Foundation's (ARF) School for Addiction Studies, learned about Thunder Bay's solution to alcohol management in park and recreation areas.

Provincial recreation directors, municipal councillors, community association executives, recreation educators, reeves and mayors, and leading citizens, heard how Thunder Bay decided to deal with the problem. For a change, delegates discussed regulations at a local instead of provincial or federal level.

Sudbury Mayor Peter Wong said his city was very much aware of the alcohol crisis facing most Canadian communities.

"In the north," he said, "we have cause for concern because we know that the consumption of alcohol in many northern communities is above the provincial average . . . social problems and health problems also increase — so does the risk of disaster due to drunken driving."

This was the workshop's theme question — how does a community, particularly one

Policy poster: listening to the people

in the north, develop an alcohol management policy which defines the situation, takes in all sectors of society, and provides clear direction on the day-to-day management of problems which *do* arise?

As Mayor Wong defined it: "The goal is to effect a societal change in how we accept our responsibilities as citizens. These societal changes must begin at the community level."

Unfortunately, it seems almost axiomatic that it is usually trouble which forces change. And the 1976 incident at the municipally-owned Chappel's golf club "was the straw that broke the camel's back," as Mrs Thomson describes it.

"Upstairs in the banquet area there was a party going on," she says. "A family came in to the ground floor, the father was going upstairs with his son, and a chair came flying over the bannister and hit the child in the head.

"The father was advised by his lawyer to sue the city . . . and that, preceded by a whole lot of other happenings over a period of time, encouraged us to get our act together. The council had been talking about an alcohol policy, but they needed this to proceed."

She says the "it-can't-happen-to-us" syndrome is probably responsible for the fact most Canadian communities are bereft of a functional, dynamic policy. Similar problems must exist everywhere, she believes.

"Thunder Bay has 13 community centres operated by volunteer executives, and a lot of functions in these centres are alcohol related. We had complaints of parties spilling over into the neighborhood, complaints of people coming out of parties in community centres and urinating all over the beautifully kept lawns. We had garden furniture taken from people's property. We had people calling us at 8:30 in the morning to complain.

"Isolated, these incidents were no big deal — they looked like a storm in a teacup — but put together, they proved we were having problems, and we didn't have a policy to deal with them."

Joint effort

The result was a joint effort between the ARF and the city council, culminating 18 months and 1,800 manhours later in the Thunder Bay Alcohol Management Policy, the first of its kind in Canada, as far as is known.

The policy is written from a public health perspective and was developed after rigorous investigation and research by a team comprising community representatives, city planners, and the ARF. It's also part of an on-going evaluation by the ARF's Community Programs Evaluation Centre.

From the beginning, says Mrs Thomson, ARF program staff played major roles in framing content and in developing the final product. And the key to the entire process was community involvement with three sets of players in the game — politicians, the public, and municipal staffers. But there were initial difficulties.

"Policy decisions are usually made by the more influential or powerful people in the community, people who can yell the loudest," Mrs Thomson says. "And so you don't get true representation on an issue such as alcohol management.

"In our community, when we listened to the people who were making the most noise, they were demanding that we put bars in every single facility that we owned," says Mrs Thomson. The point is confirmed by Ron Douglas, the ARF's northern regional program consultant, based in Sudbury.

"Marg and I ran into this when we were working on the Thunder Bay policy," he said. "The first people we spoke to said in no way did they want any restrictions. That would be the worst thing.

"But once we got past this group, and talked to the general membership, things were fine. They could see a policy would be better for them, and better for everyone."

Specific rules

Thunder Bay originally adopted its alcohol management policy in 1980, but revised it during 1981 and 1982. Under it, all open spaces owned or leased by the parks and recreation department are designated areas where the consumption of alcohol is prohibited. There is a bush camp at Centennial Park and Chippewa Lodge where alcohol can be served, but only with a special occasion permit (SOP).

The same ruling applies in community centres, but executives in charge are responsible for deciding whether or not alcohol should be served on the premises at all.

Alcohol can be served on floor surfaces in arenas, but drinking in the seats is illegal. The policy also prohibits serving alcohol during any sporting event, live performance, or film presentation.

Drinking is illegal on all golf fairways, but alcohol may be served in municipal clubhouses under an SOP. The district's two senior citizen centres can serve alcohol with SOPs, and the Fort William Curling Club operates under a lease agreement, making it eligible for a dining lounge and lounge licence.

Trowbridge and Chippewa Park tourist camps both permit the drinking of alcohol in tents or recreational vehicles and in an area up to 20 feet away.

Since the 1982 holiday weekend incident, alcohol is banned completely within the Chippewa park and tourist camp areas from 8 am on June 30, until 8 am on July 4.

But that, says Mrs Thomson, is Thunder Bay's policy. And, in her view, there is very little value in the copying of one community's approach by other communities.

Community approach

What's important is the process — the identification by individual communities of their own problems and the development of their own specific solutions. (See — Basic steps — below).

Says Mrs Thomson: "We feel we now have a policy which will stand us in good stead over time. But I often get letters asking for a copy of our policy, which I don't send because it *should* be irrelevant to your community.

"Until you've gone through that investigative process to discover your particular community's values and needs, replicating another policy is just like sitting down and writing it yourself without consulting anybody."

She says there are, however, three fundamental questions for people to ask themselves concerning alcohol management in the community and a workable control program:

1) How appropriate is it for municipal leaders to legislate controls affecting individual freedom of choice about the use of alcohol in free time on municipally owned or operated recreational facilities or property?

2) How are divergent views, values, and beliefs within the community surrounding the use of alcohol in recreational settings, drawn together?

3) And what role do recreationists have in the sensitive area of societal management or control?

Organizing an alcohol management policy is a long-term community project, but done properly its effects outweigh the effort involved. In Thunder Bay, for example, Mrs Thomson says the 1983 July 1 celebration didn't cost a cent in clean-up fees, and no liquor violation tickets were issued. "And we had people ringing us at 8:30 in the morning saying thank you, instead of complaining."

Basic steps to tailoring policy

- **Develop a collaborative relationship with community resources, such as the ARF. Use them for advice on planning strategy, background information, and expertise on alcohol related matters.**
- **Form a working group or task team. Include politicians, the public, and planners on an equal-responsibility basis. Be sure members analyze and consider their individual drinking habits when making policy recommendations.**
- **Define and draft terms of reference. This breaks down into eight basic steps:**
  1) **gather and review epidemiological data on alcohol use/abuse in your community;**
  2) **collect and review comparative information from other municipalities;**
  3) **identify facilities and programs to be covered by the policy;**
  4) **pin-point areas over a five-year period in which both good and bad management of alcohol has affected municipal facilities and programs;**
  5) **be thoroughly familiar with the Liquor Licence Act as it applies in your community;**
  6) **poll other agencies, organizations, groups, associations, individuals connected with specific facilities to determine how they see the use, or non-use, of alcohol in municipal facilities;**
  7) **determine community-specific goals and objectives; and**
  8) **seek active input from recreation department staff on the use of alcohol in community-owned facilities.**
- **Use the task team to identify appropriate policy options. This includes making sure team members know the purpose, goals, and objectives of the local parks and recreation department; gathering and reviewing information on alcohol prevention measures; studying the literature on alcohol use in recreational settings; familiarizing members with provincial legislation dealing with alcohol use; comparing policies developed in other communities; carrying out a cost/benefit analysis of alcohol-use options; gathering information and views from all concerned individuals and organizations.**
- **Develop a team position on policy recommendations and a strategy for presenting the final policy to municipal councils. For example, the Thunder Bay task force decided to use one of its own members to present the policy to council, instead of making it the responsibility of the policy planner. They believe this achieved a more effective hearing.**
- **Transform the written policy into action. Divide this into *mandatory compliance* —action enforceable through bylaws and/or regulatory procedures associated with a policy decision — and *voluntary compliance*, or action created through voluntary behavior. This is achieved, for example, through effective public education and mass information programs, making full use of the local media. This also involves developing messages for publicizing policies. The more effective this process, the greater the public compliance.**
- **Carry out an on-going evaluation of your policy. Develop a questionnaire to investigate: attitudes toward the use of alcohol, legal control, and alcohol control generally; individual responsibilities in management programs; attitudes toward the use of alcohol in recreational facilities; future intentions, ie, future rental of facilities, attendance in facilities without alcohol permits, and compliance with the law; past behavior; attitudes toward your own alcohol policy; knowledge of policies in other communities; alcohol consumption within your community; and relevant demographic information.**

THE BACK PAGE

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The Journal

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Drugs and the law — police powers p9-10

Women and alcohol p5-6

Medical resources grossly inadequate

Young Britons beg, borrow, steal for heroin

By Alan Massam

MANCHESTER, Eng —The steep rise in heroin addiction among young people in Britain has finally started alarm bells ringing — particularly among doctors.

This was evident at the annual representative meeting of the British Medical Association here when delegates heard first-hand accounts of an escalating problem for which medical resources are grossly inadequate.

Dr Hamid Husain, a family doctor from the northern city of Rotherham, set the tone for the meeting when he said not just the health of young people, but the very fabric of society is at risk.

Consultant psychiatrist Ifti Achter, who runs a drug treatment centre in Birmingham, said heroin addiction should be regarded not as an epidemic, but as a plague. It is rapidly getting out of control and addicts are getting younger and younger, he said.

Young addicts on city housing estates are sniffing heroin which makes them quickly dependent on the drug yet only provides relief from withdrawal symptoms for a few hours.

As a result, the addicts will ultimately graduate to injecting the drug. Their life expectancy is about two years, he said.

Dr Achter said his clinic is seeing 30 new unregistered users (ie, not documented on Home Office files) every month. This represents a massive increase in usage, although addicts seeking treatment are only the tip of the iceberg, he said.

Sniffing heroin can produce dependence on the drug in a week yet is hard to detect. Most addicts are presenting for treatment at about age 18 and report they have been using the drug for about two years.

He said youngsters beg, borrow, or steal to buy the drug and often turn to prostitution for funds.

A Liverpool practitioner endorsed Dr Achter's warnings. Mervyn Goodman told the conference the chief probation officer for Liverpool has reported a 640% increase in the number of drug clinic clients, the majority in the 16 to 25 years age group.

Dr Goodman said sniffing heroin is easier and more acceptable to the addict yet harder to detect.

He added that changes in the law would not solve the problem. What is needed is more support groups for addicts; better health education about drugs; better training for medical students; and an increase in the number of specialists able and willing to treat drug dependents.

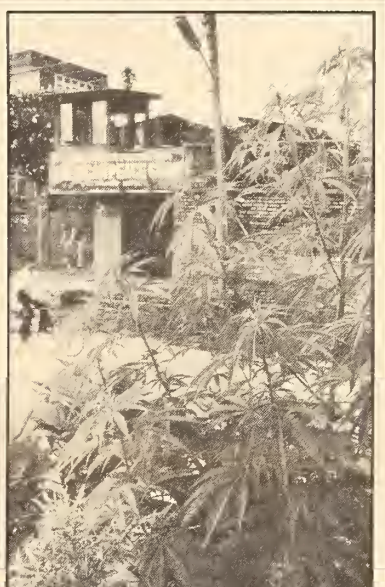
"This is a social disease. It is a social malignancy," Dr Goodman said. "If it is not resolved, the work of the doctor will be thwarted in all directions. In my opinion, it is a more serious problem than alcoholism or smoking."

A family doctor from London, Peter Toon, told the conference he is seeing addicts daily, although he cannot offer them adequate treatment. The drug treatment centre in Hackney (Dr Toon's practice area in East London) is staffed by one part-time psychiatrist and one part-time receptionist with two local authority social workers to support them.

"You might think this a modest establishment to deal with the drug problems of one of the poorest inner-city districts in the country. But, in fact, the centre is a regional unit for the whole of the North East Thames Region (a vast area of East and North East London and the county of Essex with a population of two million plus).

"If an addict walks into my sur-

(See — Curb — p 2)



Colobitsh

Katmandu's 'Freak Street' changing

Young foreigners still flock to Nepal, but now native drug abusers outnumber by far those visiting. Heroin is the drug of choice; local cannabis (right) is virtually ignored —**The Back Page**

Med schools failing in addiction studies

By Betty Lou Lee

TORONTO — Ontario's five medical schools spend no more than 0.5% of teaching time on addictions, even though 10% of the patients in the students' later practices will have alcohol and other drug problems.

The survey was done by the addictions section of the Ontario Medical Association (OMA), and results were reported at the annual meeting here by Jim G. Rankin, MD, professor of preventive medicine and biostatistics at the University of Toronto (U of T).

The University of Ottawa devoted 25 hours of teaching time to addictions, followed by Queen's University, Kingston, with 15 hours, U of T with 14 hours, and University of Western Ontario, London, with nine hours.

McMaster University at Hamilton was credited no hours, but its chairman of undergraduate medical education, Victor Neufeld, MD, later said specific hours couldn't be calculated for the survey because of McMaster's teaching methods. Students are given biomedical problems to solve, which are discussed in small group tutorials, and Dr Neufeld said several of those problems include alcohol and other drug abuse.

Dr Rankin said addictions shouldn't be an isolated topic in medical training; it should be diffused throughout the overall medical course. "The important thing is not a large block of time, but that it be integrated with biology, nutrition, etc."

He said student responses to a core course on addictions in the third year of the U of T program have not been favorable. "Any course that's very factual gets a five out of five. One that involves how to treat factors in behavior gets 1.5 to two."

Elective and selective training is centred in specialized settings such as the Addiction Research Foundation Clinical Institute or the Donwood Institute that are "out of the mainstream.

"Students may be told it's important, but they don't see it in clinical settings."

Dr Rankin added that one aspect of improving the U of T training in addictions was "exploration of methods of developing effective role models in clinical settings."

While student interest in addictions may be low, the addictions section of the OMA, to which Dr Rankin spoke, is evidence of an increased interest by practising physicians.

Formed one year ago with 72 founding members, it now has 145 members.

Dr Robert H. Johnson of Toronto, section chairman, said the formation of a Canada-wide association of doctors working in addictions is going to be explored.

Quit-smoking study gets green light

US to aid Canadian team

HAMILTON — A United States National Institutes of Health (NIH) grant of almost $1 million (Cdn) has been awarded to two Ontario universities to test the effectiveness of family doctors in getting their patients to quit smoking.

The three-year project will involve 60 physicians and 2,400 patients in southwestern Ontario.

The research team is composed of Ray Gilbert, MD, professor of family medicine, Douglas Wilson, MD, associate professor, department of family medicine, and Wayne Taylor, assistant professor, department of clinical epidemiology and biostatistics, all at McMaster University here; and Allan Best, PhD, chairman, department of psychology, University of Waterloo, Waterloo, Ontario.

Their proposal was the highest ranked among 110 smoking cessation project applications submitted to the National Cancer Institute of the NIH, Dr Gilbert said. "It's a bit unusual for a grant of this size to be awarded outside the US."

Each of the 60 family doctors will be taught one of two behavioral modification techniques and will use it with 40 patients who agree to try to stop smoking.

At the end of a year, the patients will undergo breath analyses by the research team to determine if they are still not smoking. The effectiveness of the two techniques, which Dr Gilbert declined to describe so as not to influence results, will then be compared.

"If the family doctor could double the normal stopping rate, which is about 10% over a year, it would have tremendous ramifications," said Dr Gilbert.

INSIDE

NEWS

Tobacco, alcohol advertising curbs suggested

Ontario MDs call for increase in drinking age

By Betty Lou Lee

TORONTO — The Ontario Medical Association (OMA), has come down hard on tobacco use and drinking-driving at its annual meeting.

Delegates to its General Council, representing 14,000 physicians, voted in favor of:

- raising the legal drinking age to 21 from 19;
- raising federal and provincial tobacco taxes;
- eliminating "happy hours;"
- banning tobacco advertising links to Canadian athletes and sports events;
- extending the RIDE (Reduce Impaired Driving Everywhere) program throughout the province and throughout the year, not just at the Christmas season; and,
- curbing alcohol advertising.

The alcohol recommendations came from the OMA's committee on accidental injuries. Its suggestion to raise the legal drinking age brought most of the controversy in the debates. The vote in favor was 66 to 60.

Committee chairman Frank Baillie, MD, of Hamilton said it questioned the advisability of "combining an introduction to both driving and drinking privileges within the three-year span of 16 to 19 years."

He noted that 25% of all drinking drivers involved in Ontario accidents are less than 21 years old, but this age group holds fewer than 10% of the drivers' licences.

Opponents of the resolution argued that raising the legal age would increase highway carnage, because young people would be drinking from bottles "in gravel pits and side roads," rather than in licensed premises, where owners have a legal liability not to serve them when they are approaching impairment.

One doctor from an area near the United States border said it would increase impaired driving, because young drinkers would drive to US states with a lower drinking age.

Others said the move would encourage disregard for the law, because a higher age would be unenforceable.

There was less opposition to the recommendation that the hospitality industry be encouraged to stop "happy hours" which "foster high volume alcohol intake by potential drivers within a limited time frame."

The committee cited a 1978 US study which showed that a price reduction during a three-hour afternoon period significantly increased alcohol consumption among both casual and heavy drinkers. Both groups reduced their drinking with a return to standard prices.

The OMA will urge Ontario's Attorney-General "to eliminate media advertising which may misrepresent lifestyle associated with alcohol and lead to excessive consumption."

The tobacco recommendations came from the OMA committee on public health, chaired by Dr James H. Thornley of Hamilton, and what little opposition there was was philosophical.

Toronto psychiatrist Dr Garry E. Prince questioned the principle of asking for greater government intervention in people's lives when doctors are arguing against such intervention in their practices and the effectiveness of "trying to legislate behavior."

In addition to asking for high taxes on tobacco, the council suggested this money be used for research into smoking cessation, programs to prevent children from starting, and promotion of activities which have been shown to reduce consumption.

It also supported OMA promotion of activities such as anti-smoking spot commercials on television.

Briefly. . .

Home for supper

WINNIPEG — Manitoba drinkers may not be home for evening meals following the repeal of a 28-year-old law requiring beverage rooms to close for one hour between 6:30 and 7:30 p.m. The law, apparently designed to send patrons home to supper, was started to preserve family life, reports *The Globe and Mail*. However, in recent years, patrons could simply move on to a club or lounge not bound by the supper closing law.

Help for MDs at risk

ST JOHN'S, Nfld — Doctors with alcohol or other drug abuse problems and serious emotional family problems will be able to get help here from a physicians-at-risk committee established recently by the Newfoundland Medical Association (NMA). The NMA plans to recruit two "interveners" in each district of the province to approach and assist physicians, reports *The Medical Post*. Only if medical help is refused and there is evidence of medical malpractice will the committee refer the impaired physician to the province's medical board.

Project SMART

WASHINGTON — The Centre for Science in the Public Interest here and the United States National Council on Alcoholism have joined dozens of national and local organizations in the US to push for an end to radio and television advertising of alcoholic beverages, or at least equal time for health messages. Project SMART (Stop Marketing Alcohol on Radio and Television) is a campaign aimed at collecting one million signatures on petitions to President Ronald Reagan and the Congress.

Medicine for kids

EVANSTON, Ill — The American Academy of Pediatrics (AAP) has called for greater control of the alcohol content in liquid medicines for children. The AAP points out that more than 700 liquid medicines contain ethanol in concentrations between 0.3% and 68%. They have called for a limit of 5% alcohol in over-the-counter medications for children and have also asked for small, safety-sealed packages for any alcohol-containing medication.

Beer for the young

TORONTO — A candy company may be trying to attract a new generation of drinkers in Australia with jellied candy that looks and tastes like beer. The jellies — shaped like a pint glass and with white frothy heads and "beer" written on them — have been popular on a trial run. Plans call for 60 tonnes to be sent to Australia soon, reports the newsletter of the Alcoholic Liquor Advisory Council of New Zealand.

Lung problems seen in cocaine smokers

By Harvey McConnell

ST LOUIS, Mo — Contrary to the belief of many cocaine users, preparation of freebase cocaine for smoking does not eliminate all contaminants present in the street drug, suggest studies by Sidney Schnoll, MD, and colleagues at Northwestern Memorial Hospital, Chicago.

And smoking cocaine can cause serious pulmonary dysfunction, Dr Schnoll said in a report here to the annual scientific meeting of the Committee on Problems of Drug Dependence. (Freebase cocaine is preferred for smoking; a smaller proportion of it, than of cocaine hydrochloride, decomposes when heated.)

Dr Schnoll said that when he arrived at Northwestern four years ago only two or three of the 100 people admitted per month to their treatment centre used cocaine. Today at least 50% of people admitted are cocaine users.

About 70% of the cocaine users said they were freebasing, and most reported respiratory symptoms, such as productive cough of black or bloody sputum. Dr Schnoll and colleagues decided to study pulmonary function in clients who were freebasing cocaine, but not using other drugs; it turned out to be "very difficult to find many relatively uncontaminated cocaine users," he commented.

The researchers eventually found 15 cocaine-only users on whom they did routine physicals, chest x-rays, and lung function tests. Most of the patients were cigarette smokers as well and had freebased cocaine for at least six months before admission to the study.

Dr Schnoll said the major problem in 10 of the 19 patients was in diffusion capacity — the ability to transfer oxygen across the alveoli into the blood stream and to transfer carbon dioxide out. The 10 had diffusion capacity less than 70% of predicted normal value.

Dr Schnoll said the findings suggest inhalation of freebase affects the gas exchange capacity of the lungs. "Whether this is due to the vasoconstrictor properties of the cocaine itself, or other adulterants, is unknown."

Dr Schnoll said they found many contaminants in supplies of cocaine already prepared for smoking which they submitted to analysis. "This is interesting because one of the myths believed by freebase smokers is that they are purifying the cocaine."

Dr Schnoll said that only two of the patients who showed reduced diffusion capacity were available for follow-up 10 months later. Neither showed any improvement in diffusion capacity even though they had stopped freebasing.

Papal poster: *Proceeds from the sale of the official poster commemorating the visit here of Pope John Paul II will go to the Toronto-based Council on Drug Abuse (CODA). The posters will be sold through a major Canadian drug store chain.*

Brain's reward mechanism triggered

Heroin/cocaine actions similar

By Harvey McConnell

WASHINGTON — Many of the actions of heroin and cocaine are different in the brain, but both can ultimately activate the same reward mechanism, suggests research at Concordia University, Montreal.

"We conclude that 'addiction' as defined by physical dependence is not the critical factor in drug abuse," says Roy Wise, PhD, centre for studies in behavioral neurobiology at Concordia. "What makes heroin and cocaine habit-forming is their rewarding action."

Dr Wise made his comments at a science-press seminar held here by the United States Alcohol, Drug Abuse, and Mental Health Administration.

He and colleague Michael Bozarth, PhD, study the various behavioral effects associated with separate brain mechanisms by injecting drugs directly into different regions of the rat brain.

Cocaine and heroin each have multiple effects which are associated with different regions of the brain and with different chemical messengers. But, the researchers have shown both cocaine and heroin activate the circuit of the brain that is responsible for producing the pleasurable sensation of "reward."

Dr Wise said their studies make it clear that cocaine shares more with heroin than is generally acknowledged. Rats learn to lever-press for intravenous cocaine about as quickly as they learn to lever-press for heroin, suggesting both drugs have approximately equal rewarding-impact when given in optimal doses.

Based on their research into the ability of both cocaine and heroin to activate the common brain reward mechanism, "it is difficult to say which is the more dangerous drug," Dr Wise added.

The research is financed by the US National Institute on Drug Abuse, the Canadian Medical Research Council, and the Natural Sciences and Engineering Research Council of Canada.

Curb heroin, says BMA

(from page 1)

gery (office), I have nothing to offer him, or her, except the support of an untrained GP (family physician). We would not accept this situation in our coronary care or renal units, so why should we accept it for this equally life-threatening disease?"

A physician from a rural area, a seaside town in the county of Norfolk, revealed that the heroin problem is not confined to cities.

Patricia Allington-Smith told the conference she had been approached by a young woman who had been an addict for eight years and had just had a baby. The girl said she was convinced she would lose the baby if she did not get help, but Dr Allington-Smith had been appalled to find that she could only be offered an appointment one month ahead at a clinic 80 miles away.

"She could have been my daughter, she could have been your daughter," Dr Allington-Smith said. "The lack of facilities for this problem is absolutely scandalous."

Clearly moved, the annual representative meeting, known as the British doctors' "parliament," decided to urge the government to:

1. strengthen the law to prevent young people from becoming victims of drugs;
2. fund clinics and support groups to help victims and their families; and,
3. seek ways of reducing the importation of heroin into Britain.

'Little consensus about what we know'

DWI research energy often wasted, repetitive

By Harvey McConnell

BALTIMORE, Md — Alcohol and traffic safety is such an explosive issue that it is hard even to identify research needs and opportunities, says Herbert M. Simpson, PhD, executive director of the Traffic Injury Research Foundation of Canada.

"Unfortunately, there exists little consensus either about what we need to know, or what we already know," he told the 1st North American Conference on Alcohol and Highway Safety here.

Dr Simpson said alcohol and traffic safety as an issue has profound social and political implications. "Accordingly, rational and systematic initiatives often give way to political and social exigencies."

It is, thus, not surprising that research energy is often wasted on unproductive, often repetitive activity, and many vital questions go unanswered, he said.

"At the extreme, there are those who assert that our knowledge base is perfectly adequate and what is needed is more effective use of that knowledge; at the other end of the continuum, there are those who argue that our knowledge base is frightfully inadequate and even the most basic data are lacking — for example, it cannot be stated with any degree of certainty how many crashes are alcohol-related."

Dr Simpson noted that, in the case of the drinking driver, any "profile" is sketchy at best of those at greatest risk of being in a collision or at risk of being charged with driving while impaired (DWI).

It is important to go "far beyond the traditional sociodemographic measures of age, sex, occupation, and socioeconomic status to include a broad range of personality/attitudinal variables that touch on the two critical, interrelated dimensions — drinking style and driving style," Dr Simpson continued.

Evidence is mounting that suggests driving skill is no more important than driving style, yet knowledge about such factors is very limited.

Dr Simpson added: "There is evidence that drinking is not correlated with accidents/violations, unless it is accompanied by an aggressive predisposition. How reliable is this finding? How far does it extend into other age/sex groups? Is it valid for DWI offences?"

The most critical need for future research is adequate control of exposure to risk, both in terms of quantity and quality.

He said the majority of studies to date have merely compared the prevalence of an attribute, characteristic, or trait in a special group (such as DWI offenders) to the prevalence of that attribute in a control group (such as people with violation- or conviction-free records). Over representation of the attribute is regarded to be of some significance.

As an example, Dr Simpson explained, it has been found that the accident/violation experience of frequent drinkers is lower than that of heavy drinkers.

"While the results of such work are provocative, suggesting that the moderate, but frequent, drinker is a low-risk relative to the frequent heavy or infrequent heavy drinker, it could be argued that the frequency/quantity variable is merely indicative of other differences, such as the amount of driving or the conditions/circumstances under which the driving occurs," Dr Simpson said.

Frank Haight, PhD, professor of statistics and transportation, Pennsylvania State University, told the conference: "We have produced a body of research which is shallow, not deep; tendentious, not objective; fragmentary, not coordinated; dictated by fashions and trends, and often of very little scientific validity. In these circumstances, it is entirely comprehensible that drinking driving is a poorly and vaguely understood phenomenon in comparison with other contributions to mortality and injury."

Dr Haight said it has been generally assumed, or at least not really challenged, that the mediating factor is the well-known effect of alcohol on driving skills. The presence of this effect has been repeatedly demonstrated, and it may be one of the best known facts about drinking and driving.

"But little or no attention has been paid to the possibility that it may not be substantially this effect that results in accidents. There are reasons to believe that another factor, namely change in emotions and attitudes, may be at least as important," he said.

Dr Haight said the various other mishaps that afflict alcohol abusers seem to stem from a lack of emotional stability as much as a lack of motor control. "Drunks are knocked down in bars more because they are pugnacious than because their ability to dodge is impaired."

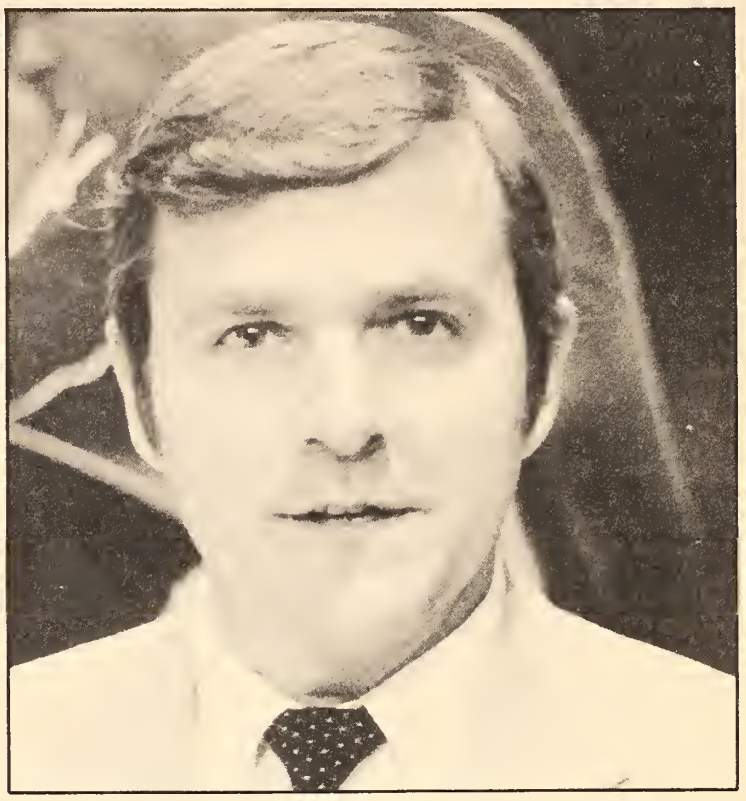
There is also an established link between alcohol and suicide, although Dr Haight made it clear he is not claiming "any substantial proportion of traffic accidents is deliberately suicidal.

"But it does call attention to a reverse logic: not that alcohol causes desperate acts, but that desperation may involve first of all excessive drinking. Or, in the context of driving, that alcohol may induce not only involuntary risk taking, but also voluntary risk taking."

Dr Haight said the moral component of drunk driving is concealed in North America, but a simple truth should be faced: "There is a strong feeling that a fatality caused by a driver who is drunk is in an entirely different category from the same fatality caused by a driver who is fatigued, inattentive, or elderly, even though these conditions may induce nearly identical driver performance characteristics."

In the case of drunk driving, it should be acknowledged that the purpose of jail is social revenge, not accident prevention, Dr Haight added. But this is not to claim that jail is an undesirable option or that revenge is not justified.

The conference was sponsored by the Alcoholic Beverage Medical Research Foundation at the Johns Hopkins Medical Institutions here. The foundation is supported by the Brewers Association of Canada and the United States Brewers Association.



Simpson: many vital questions go unanswered

Public is weak soldier in drinking/driving war

BALTIMORE, Md — Single-minded determination to reduce driver mortality and morbidity is the key to controlling the alcohol factor in drinking and driving.

Robert Borkenstein, BSc, professor emeritus of forensic studies and director for Law Studies in Action, Indiana University, Bloomington, Indiana, told the 1st North American Conference on Alcohol and Highway Safety here that public support is the weakest link in attacking the drinking and driving problem.

"What we perceive as low-level action against the drunk driver is probably a direct result of public attitudes and (lack of) support," he said.

People can be informed, and laws can be enforced, and fear can, for a while, change behavior. "But, when we fail to change attitudes, regression is bound to occur," he said.

Prof Borkenstein said control of the alcohol factor will not be accomplished until everyone — "scientists, automobile manufacturers, government agencies, and the general public" — looks at the problem with only one objective, the reduction of driver mortality and morbidity.

The conference was sponsored by the Alcoholic Beverage Medical Research Foundation at the Johns Hopkins Medical Institutions here. The foundation is supported by the Brewers Association of Canada and the United States Brewers Association.

Coming up in

The Journal

- UN agencies battle Third World tobacco dilemma
- Reports from the 25th annual Institute on Addiction Studies

Howell proposes Swift action on drunk driving

By Wayne Howell

The practice of rewarding virtue as a means of social control rather than punishing vice has never really caught on in human societies. Indeed, about the only place one tends to come across the idea is in Utopian fiction. In Jonathan Swift's Lilliput, for instance, the whole legal system was enforced by a system of rewards. Anyone who could show he had obeyed the laws for 73 moons was granted privileges paid for by a state fund and received a non-hereditary title.

To me, the mad rush to raise the drinking age to 21 years all over North America, as a means of reducing alcohol-related traffic fatalities, is an example of our penchant for punishment. In this case, a whole age-set is punished because of the actions of an irresponsible few. Ironically, the same governments that pushed and prodded private insurance companies to stop punishing all youthful drivers for their youth and/or their sex by way of automatic high automobile insurance premiums, and encouraged the companies to set rates on a case-by-case basis, are now acting like the insurance companies of old.

It would be refreshing to see how the Lilliputians would handle the situation. Since the problem on the highways is not one of drinking, nor one of driving, but a combination of the two activities, they would probably consider offering young people a choice: you can have the drinking privilege or the driving privilege, but you can't have both — take your pick. Each person could then choose the adult privilege he felt would be most useful, or most pleasurable. A single "age of majority card" would be issued showing the individual's choice. No one with a "driver" card would be able to buy liquor, and no one with a "drinker" card would be able to operate a motor vehicle. Tavern waiters or police could easily ascertain the status of any individual by looking at his card.

Of course, the Lilliputians would recognize that a person's preference varies over time, and so, once a moon, the individual could change his status from "drinker" to "driver" or vice versa. (This "flipping" of status would be actively encouraged, so that the acquisition of responsible driving skills and responsible drinking skills could occur almost — but not quite — simultaneously.)

And of course the Lilliputian system of reward rather than punishment would take into account the fact that there are some young people who are just as responsible as some older people when it comes to drinking and driving. Therefore, if a person had an unblemished driving record for 40 moons (approximately three years) he would be allowed a "double privilege" card; likewise, a person with an unblemished drinking record for 40 moons would also get a double privilege card, equivalent in all respects to the cards held by older persons.

Any driving infraction and any drinking infraction would result in the automatic suspension of whatever privilege was held for a period of 20 moons. Then the individual could once again make his choice and once again start working toward his goal of 40 moons free of infractions, assuming a double-privilege card was something he or she found desirable.

I have described the bare bones of what I think the Lilliputian solution would be. Naturally, there would be many refinements. For instance, other rewards for civic virtue of one kind or another could be used to reduce the 40-moon waiting period if a person wished to do so. Since in Lilliput good morals were more highly rated than great abilities, this would not mean that young persons of superior intellect, capable of academic achievements, would be at an advantage. For a young person could accumulate an equivalent number of rewards by being a regular blood donor or performing some other useful community service.

The Lilliputians were a very tiny people — no more than six inches high, according to Lemuel Gulliver, who discovered them in 1699. So I guess it is not possible that they were more grown up than we are.

NEWS

RESEARCH UPDATE

Disulfiram implantation

Disulfiram implanted under the skin effectively increases the degree of sobriety in alcoholic patients over a two-year period, regardless of the quantity of the drug used, a Canadian study reports. One hundred and twenty patients (92 male, 28 female) in the Winnipeg area who had been treated for alcoholism volunteered to receive 800 milligrams, 1,200 mg, or 1,600mg of disulfiram, which can cause unpleasant symptoms when patients drink alcohol. Approximately two years later, two-thirds of the patients were located and interviewed. Twenty-one of 30 in the 1,600mg group, 10 of 30 in the 1,200mg group, and 10 of 22 in the 800mg group claimed they had been abstinent since their implant. This difference was not significant. Neither was the distribution among the three groups of the 14 of 41 patients who reported drinking again and having a disulfiram-ethanol reaction. While the researchers from the departments of psychiatry and surgery, University of Manitoba, said the implant was apparently effective in reducing drinking behavior, the reduction was independent of the size of the implant within the dose range used in the study. They said this finding could be due either to the psychological deterrent component of the therapy outweighing the differing pharmacologic effects of the implant dosages, or else only a certain quantity of disulfiram is needed and any additional dosage is ineffective. There was no control group "for ethical reasons, based on the demonstrated effectiveness of the disulfiram implant in previous controlled trials in this series," and because "changes in the procedure for obtaining informed consent render placebo-controlled trials of anti-alcohol drugs of dubious value."
Journal of Clinical Psychiatry, June 1984, v.45:242-247

Underarm nicotine

Application of a solution of nicotine to the underside of the forearm can produce a nicotine level comparable to that produced by cigarette smoking, three California researchers have found. A nine milligram nicotine base was applied to the skin of a 31-year-old non-smoking volunteer. Salivary nicotine, heart rate, and blood pressure were monitored for 12 hours. All were found to rise during that period. The researchers, working in the department of psychiatry, Centre for Health Sciences, University of California, Los Angeles, said the transdermal administration of nicotine had several potential advantages over the oral, intravenous, or buccal administration of nicotine. "Although the transdermal nicotine was not absorbed as rapidly as in smoke from a cigarette, the sustained elevation in systemic nicotine levels suggests that it may be a promising strategy for reducing craving and smoking withdrawal symptoms." Further study is needed to show whether giving nicotine in this way can reduce cigarette craving, the study concluded.
Drug and Alcohol Dependence, May 1984, v.13:209-213

Alcohol/cholesterol finding unexpected

California researchers studying moderate alcohol consumption and cholesterol levels have uncovered some unexpected results. The Stanford Heart Disease Prevention Program of Stanford University, and the Donner Laboratory of Medical Physics, University of California, Berkeley, concentrated on the two subfractions of high-density lipoprotein (HDL), HDL_2 and HDL_3. While less dense HDL_2 appears to be negatively associated with coronary heart disease, more dense HDL_3 appears to be unrelated. Since alcohol consumption correlates with both reduced coronary heart disease and increased plasma HDL levels, the researchers were expecting a strong relationship between alcohol and HDL_2. In an 11-week trial, 24 healthy men were divided into two groups with a control group maintaining normal, moderate alcohol consumption, and the treatment group abstaining for the first part of the study, and then resuming their normal, moderate alcohol intake. The "unexpected conclusion" was that while concentrations of HDL cholesterol and HDL_3 mass decreased during the abstention period and increased when drinking resumed, HDL_2 mass did not change. The researchers said the direct dose relationship between alcohol intake and serum HDL_3 was independent of weight loss experienced by the subjects. They concluded that among moderate drinkers "the association between alcohol intake and coronary heart disease is not mediated by increases in HDL_2 mass" as expected, and the HDL_3 fraction may not be inert with respect to coronary heart disease as previously believed, or the association "may operate through a mechanism unrelated to HDL."
New England Journal of Medicine, March 29, 1984, v.310:805-810

Patient/doc credibility gap warning

Smoking cessation can aggravate asthmatic symptoms, say two Swedish researchers. They questioned 125 patients with asthma about changes in symptoms after they stopped smoking. Fifty-nine reported they stopped smoking either permanently or for short periods of time. Almost one-third (18) said their asthma worsened when they stopped, while most of the remainder said their asthma improved. G. Hillerdahl and R. Rylander of the department of pulmonary medicine, The Academic Hospital, Uppsala, and the department of environmental hygiene, University of Gothenburg, Gothenburg, stressed that because the case histories were subjective, psychological explanations might explain the worsening of the asthma when some patients stopped smoking. But, because of the complex effects tobacco smoke has on the immune system, they speculated that stopping smoking might upset its function, leading to worsened asthmatic symptoms. They cautioned physicians to note that a refusal of a doctor to believe that smoking cessation can aggravate asthma will lead to a credibility gap between doctor and patient.
Clinical Allergy, January 1984, v.14:45-47

Pat Rich

Children copy moms who smoke but dads' habits have little impact

By Betty Lou Lee

TORONTO — Mothers' smoking habits have a greater influence on their children than fathers', a study of Thunder Bay high school students indicates.

If the mother is the only smoking parent, 52% of the teenaged daughters and 21% of the sons will be smokers. If both parents smoke, the rate for boys will rise to 33%. But, if only the father smokes, it doesn't appear to have a significant impact on the children. Parental influence peaks as the children reach ages 14 to 15, and then diminishes.

The analysis was presented at the annual meeting of the Canadian Paediatric Society by Richard S. Stanwick, MD, of the departments of pediatrics, and social and preventive medicine, University of Manitoba, Winnipeg.

The study involved almost 1,000 students aged 14 to 18 in 1982.

It reinforced the findings of other investigators that smoking is a bigger problem among teenage girls than boys.

Seventy-five per cent of the girls had at least experimented with cigarettes, compared to 62% of the boys. For both sexes, smoking peaked at age 16, but declined for boys after that.

At age 14, 31% of females and 19% of males smoked at least one cigarette a week. By 15, it was 34% females, 27% males; by age 16, 47% females and 35% males; at 17, 48% females and 30% males; and by 18, 45% females, 28% males.

Dr Stanwick speculated one reason for the gender difference may be the "disproportionate amount of advertising directed at young women," and showed advertisements from one issue of *Glamor* magazine that were designed to appeal to feminists, women athletes, party-goers, and "soft" women.

He said pediatricians should develop strategies to combat smoking among teenage girls, since they will become mothers and, in turn, influence their daughters.

"We are facing a public health problem of significant proportions," he added.

Alcohol a 'frequent factor' in aquatic deaths, injuries

TORONTO — Most people know the hazards of drinking and driving.

The Ontario Medical Association wants just as many people to be aware of the perils of drinking and diving.

It voted to publicize such warnings at its annual meeting here, after its committee on accidental injuries reported that alcohol consumption was a frequent factor in aquatic deaths and injuries.

In 1979, 54 spinal cord injuries were associated with diving accidents in Ontario.

The danger is highest when unknown or shallow waters are involved.

Hyperactivity/alcoholism tie tested

By Lillian Wylie

LOS ANGELES — Hyperactive adolescents are more at risk for becoming teenaged alcoholics than their non-hyperactive peers.

Research presented at the annual meeting here of the American Psychiatric Association suggests that hyperactive adolescents are more likely to abuse alcohol, says Ralph E. Tarter, PhD, associate professor of psychiatry at the University of Pittsburg, Pittsburg, Pennsylvania.

Dr Tarter, a pioneer in studies of the connection between hyperactivity and alcohol, said his research — still in initial stages — demonstrates that approximately one-third of alcoholics had childhood hyperactivity.

In general, Dr Tarter says, 10% of elementary school children are considered to be hyperactive.

"Our observations that about one-third of alcoholism meets the criteria for attention deficit disorder, residual type, suggests an association between alcoholism and childhood hyperactivity."

Dr Tarter believes that family history and hyperactivity are important variables in alcoholism research. He hopes his work may be a significant aid in the prevention of alcoholism by targeting the children at highest risk for developing it.

"We find that those with a propensity for hyperactivity are associated with an early onset of drinking, a more pathological pattern of drinking, more anti-social personality, and a more self-destructive type of drinking."

Dr Tarter theorized hyperactive children abuse alcohol for its "self-medicating effects," in other words, to control their impulsive behavior. Later on, the alcoholism becomes habitual.

"The link between alcoholism and hyperactivity might be an ongoing, unbreakable cycle. In other words, with an alcoholic parent, there is an increased chance of hyperactivity; and because of that behavioral pattern, the child is at high risk of becoming alcoholic," said Dr Tarter.

"What is important is to intervene with these high-risk children before the problem starts, to educate the family and to teach the child how to cope."

US rose growers protest

Cocaine sent in with flowers

WASHINGTON — When is a Colombian rose more than a rose, and when does it not smell as sweet by any other name? When it is used to smuggle cocaine.

United States rose growers have asked the government to take action because so much cocaine is smuggled in cut flower shipments from Colombia and, they claim, blooms are being dumped on the market for a pittance.

The US Department of Commerce, while not saying anything about cocaine, acknowleged earlier this year that roses from Colombia are being dumped on the market at below market prices.

Lawyers for Roses Inc, a trade association, said in a petition filed with the Department of Commerce and the International Trade Commission that, during the working week, up to six planes a night arrive in Miami with cut flowers from Colombia. It is impossible for US customs to check every box.

The roses are sold at ridiculously low prices because the real purpose of the shipments is to bring in cocaine and traffickers are not even interested in covering the cost of shipment.

"The ever-rising flood of exports of fresh cut flowers, including roses, from Colombia to the United States is an imperative to sustain the rising flood of cocaine from Colombia into the United States," the petition adds.

A lawyer representing Colombian flower exporters said the cocaine smuggling charges were false.

A rose . . . is a smuggler's disguise

UPDATE

Women and alcohol: approaches to education

By Lavada Pinder*

It is nearly a decade since issues concerned with women's alcohol use began receiving significant attention in Canada. Prior to that time, professional and public attention was focused on men's drinking problems. Women were of interest chiefly in terms of how their attitudes and behavior might affect the lives of male alcoholics. As mothers, their roles were analyzed to determine the roots of alcoholism. Wives were counselled and coached not for stress, but to assist in the treatment outcomes of their husbands. As Kintner stated: "Historically, treatment programs have trained men to take responsibility for their lives and trained women to take responsibility for the men in their lives."

To appreciate the Canadian response to women's use and abuse of alcohol, it is essential to understand two phenomena which were occurring simultaneously. The first was a surge of interest in issues related to alcohol problems among women, and the second, the emergence of the women's movement.

In the early and mid 1970s, there were a number of milestone literature reviews and articles. The writing of Lindbeck, Schuckit, Badiet, Beckman, and Gomberg served to make Canadian health professionals in the alcohol field aware of women's special needs. Cooperstock added crucial information regarding misuse of minor tranquillizers. Women, more than men, wrote Cooperstock, combine the use of alcohol with the use of prescribed drugs.

At the same time, the women's movement was growing. At the national level, The Royal Commission on the Status of Women, established in response to requests from some 31 women's organizations, brought in its report and recommendations in 1970. At the local level, consciousness-raising groups were making practical the concepts of support and networking.

Against this background, a decade of Canadian activities relating to women and alcohol have been characterized by the collaborative, often over-lapping, efforts of those in the alcohol field and in the women's movement. Philosophically, this means alcohol problems in women have been interpreted within the context of the role and status of women in Canadian society. Programmatically, it means that feminism, self-help, and mutual-aid have provided the framework for development. Federal government programs since 1974 have adhered to these concepts. Chief among these programs has been the development of education strategies specific to the needs of women.

This article describes two such programs. One is a national education resource directed to preventing alcohol problems in women; the other is a community-based treatment program developed as a demonstration with the assistance of the federal government. To put these programs in perspective, the extent of women's alcohol use and abuse is briefly described and the programs discussed within the context of selected economic, social, and political factors which affect women's programs. Finally, recommendations are made for further development of education strategies.

Morbidity and mortality

The most recent information on the numbers and types of drinkers in Canada is contained in a report entitled *Alcohol in Canada, A National Perspective* (Health and Welfare Canada, 1984). This report indicates that 57% of women are drinkers, (they drink at least once a month) compared to 75% of men. Divorced women and those with the highest incomes are most likely to be drinkers, while blue-collar and unemployed women are less likely. The difference between male and female drinking is smallest in the youngest groups and increases steadily with age. In the 15 to 19 years age group, the difference is 9% while it is nearly 50% in the age group 45 to 64 years and 25% for those more than 65 years.

Both men and women in the lower income groups experience higher rates of drinking-related problems, despite the fact higher income groups consume more. However, the difference in problem rates between higher and lower income groups is less for women (2%) than men (6%). For both men and women, family problems are identified most frequently.

The alcohol-related mortality rate for men, in the two-year period 1979 to 1980, was 2½ times that for women, unchanged since 1975. In the same period, the cirrhosis rates for women decreased to 6.1 from 6.9, less than the 10% decrease for men to 15.0 from 16.7.

Statistics for general and mental hospital separations due to alcohol psychosis between 1972 and 1981 indicate that, although there was a large increase in the number of women, men were still four times as likely as women to appear in these institutions.

Current data from special treatment programs are only partially available. However, five out of 10 provinces reported in 1981-82 that men outnumbered women by at least 3½ times to one. Men were most evident in long-stay residential programs with the highest proportions of women in outpatient programs.

These data continue to indicate that women drink more moderately than men and experience fewer problems although, within the young age groups, there is some evidence of convergence. However, there remains concern that information based on traditional measures — that is, frequency and amount of drinking, and hospital statistics on morbidity and mortality, eg, from liver cirrhosis — may not provide a true picture.

Educational tacks

Background: The federal government's involvement in the issue of women and alcohol began in 1975 with the publication of an annotated bibliography. That same year, 1975, was one of discussion and issue definition at national, provincial, and local levels.

A recurring theme in all these deliberations was the need for education of the public, of professionals, and of women themselves for purposes of prevention and treatment (**The Journal**, Nov, 1975, Oct, 1975, Sept, 1975). As a result, the federal government assigned priority to issues related to women and alcohol, and it was the theme of education which provided the focus for federal government involvement in developing the prevention program *It's Just Your Nerves/C'est pas grave, c'est rien que vos nerfs*, and in funding the treatment program, Amethyst Women's Addiction Centre.

It's your nerves

It's Just Your Nerves is a resource kit produced in 1981 to encourage informed discussion among groups of women by giving factual information about alcohol and tranquillizers and by broadening understanding of the social complexities underlying use. It is a national version of a kit developed in Ontario in 1979.

To nationalize the resource, two advisory groups, one English and one French, provided expert advice and represented regional concerns. The target group included all women, with or without drug-related problems, as well as health professionals. However, the information base on the use of alcohol and tranquillizers and the social context in which they are misused was retained, as was the modular format. The kit was composed of an audio-visual resource, a flipchart, and a guidebook for the facilitator. Six modules deal with introducing users to the program, with minor tranquillizers, alcohol, cross-addictions, and dangers associated with taking drugs during pregnancy, and with various solutions.

Implementation of a national program in a country as geographically and culturally diverse as Canada presents special problems and challenges. Women were trained as facilitators to bring the resource to the target group. Implementation varied from region to region, but was generally conducted in four phases. First, contacts were identified in communities through existing women's networks. Second, the program was promoted through community information sessions set up by these contacts. Third, two-day training sessions were conducted with women selected as potential facilitators. Finally, the kits were deposited in settings convenient to the facilitators and known to serve the appropriate constituency.

Evaluations of the implementation of the English and French resources were conducted in 1983 and focused on facilitators rather than impact of the kit on women exposed to the resource.

Between May 1981 and April 1983, 853 women (both English and French) were trained as facilitators. In a study, 200 English facilitators were surveyed by questionnaire; 57% responded. Thirty-five French facilitators were interviewed personally, and questionnaires were sent to 144 sites in Quebec; 94% responded. In total, respondents had conducted 384 sessions (278 English and 106 French) in which 5,550 women had participated. While more than half had facilitated sessions of about 15 women, only 10% said they had used the resource sufficiently.

The majority of the facilitators were employed by government or para-governmental agencies. Those remaining were either the paid employees of women's organizations, or volunteers from women's or other community groups. The resource was universally thought to be of good quality, to be clear and concise, and to provide a flexible teaching tool. However, it was considered somewhat limited with regard to certain age groups, and very limited with regard to native and immigrant women.

There were three main reasons it was not used more extensively; the issue was not a priority of the organizations; facilitators lacked time to organize sessions; and, there was insufficient community demand. It appeared then, that the working women selected as facilitators suffered from personal and organizational time constraints. Lack of community demand is likely related either to the fact that facilitators did not have time or organizational support to promote the resource, or that it was not applicable to some groups.

Amethyst Centre

The Amethyst Women's Addiction Centre is a community-based treatment program which opened in Ottawa, Ontario, in April 1979. It was the first alcohol treatment centre in Canada designed for women, by women.

In the mid 1970s, Ottawa, a city of more than half a million people, offered a typical addictions treatment system. There were several Alcoholics Anonymous groups, inpatient and outpatient services in which women were outnumbered approximately three to one by men, and there were 20 detoxication and 48 recovery home beds, all for men. In 1975, a task group surveyed the needs of women alcoholics and developed a proposal in response to these needs.

On the basis of the survey, and an extensive literature review, a proposal was developed for a centre to provide treatment and professional and public education. The treatment program was based on the argument that women develop drinking problems in ways that differ from men and that women alcoholics differ from men alcoholics because of the particular pressures and conflicts experienced by women. In other words, women's experience with alcoholism cannot be separated from their experience as women.

The program consisted of an intensive four-week program, three days each week from 10 am to 3 pm, and a follow-up session one evening or morning each week for 11 months. Prior to entry, women were offered the opportunity to attend a weekly pretreatment group and were put in touch with an outreach volunteer.

To help women overcome dependence on alcohol and other drugs, break through iso-

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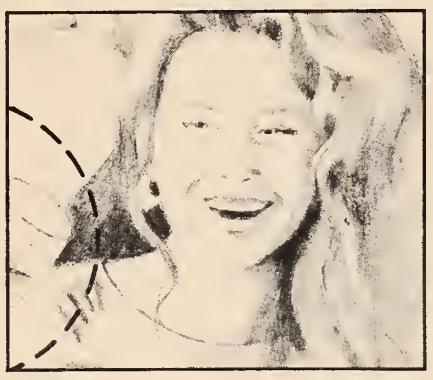
Lavada Pinder is director, program resources division, Health Promotion Directorate, Health and Welfare Canada. This article is adapted from a paper she presented to the 30th International Institute on the Prevention and Treatment of Alcoholism, in Athens, Greece in the spring.

UPDATE

Women and alcohol: approaches to education



(from page 5)

lation, raise self-esteem, combat feelings of helplessness, depression, and anger, and to reduce stress and improve health, the Amethyst program focused on women helping women in small groups. In mixed groups, men tend to dominate discussions and women may continue to play out dysfunctional roles, competing for male approval. Not only does this situation make it difficult for women to talk about personal subjects, but the latter aspect is particularly damaging to self-worth given that traditional male/female relationships have been based on dominance and submission. There was a strong belief on the part of the staff, therefore, that the key to change was in women valuing themselves and taking control of their lives.

The core of the treatment experience was education; it took place in three types of groups. Small group discussion facilitated problem identification and the collective search for solutions. Assertiveness training developed awareness of rights and identified specific needs, and used role playing and role rehearsal to learn skills to meet identified needs. The third type of group provided information on the physical and psychosocial effects of alcohol and drugs and techniques for overcoming urges to drink. The goal, regardless of the type of group, was to empower women to help themselves and other women.

Research on the effects of the program on the first group of clients was completed in February 1984. On the basis of questionnaires administered at intake, information was collected at six months and at 12 months, which included drinking behavior, degree of assertiveness, and self-esteem. The results show that women who completed the program significantly reduced their drinking behavior. Forty-six percent were abstinent, 25% improved, and 29% were drinking heavily 12 months after completing the program. This compares favorably to treatment outcomes which frequently report one-third abstinent, one-third improved, and one-third unimproved. Clients who were abstinent or drinking moderately reported positive changes in their assertive behavior and comfort with this behavior 12 months after program completion. Clients who were drinking were significantly less comfortable with assertion. Self-esteem was also significantly related to drinking outcomes at 12 months. Clients who were abstinent had higher self-esteem than others, and clients drinking heavily had the lowest self-esteem. The findings confirm the positive correlation between drinking outcome and group education efforts to improve assertion and self-esteem.

Overriding goal

The prevention and treatment program cited as examples of educational approaches are based on theories of feminism and self-help with an emphasis on social learning complemented by social support. These programs, therefore, are in line with current thinking which suggests that efforts to persuade the individual to change her behavior are inadequate unless accompanied by strategies directed to changing the environment in which decisions are taken. Far from "blaming the victim," these programs have moved toward developing awareness of social and cultural influences in order to provide a better climate for informed choice.

The overriding goal of programs for women with real or potential alcohol problems must be to enable them to make informed choices and to take control of their lives. In the face of certain economic, social, and political realities this can be a difficult task. Many factors impinge on women's lives and women's programs, and these should be fully appreciated. Education is a powerful tool, but there are also powerful competing forces.

The "feminization of poverty" is a term which describes the social and economic situation in which many women find themselves. Here are some facts:

- Women's participation in the workforce increased throughout the 1970s so that in 1981, 51.6% of all women aged 15 and older were employed compared with 39.4% 10 years before. At the same time, women remain concentrated in clerical, service, and sales occupations which accounts for the fact that the median annual income for women in 1981 was $7,925 compared to $17,555 for men. In addition, the unemployment rate among women with its accompanying stress-related health problems was 8.3% compared to 7.1% among men.
- Women need to work. Five out of six single parents are women. In 1982, the income of single parent families headed by women was $14,020, less than half that of men who head single parent families. Compounding the problem of income is the fact that the 123,962 full-time day care spaces permit only 14% of children under six with mothers in the labor force to be enrolled in licensed, regulated day care.
- Single, elderly women have an average income of $6,200, which is below the established poverty range. This reflects small pensions as a result of having earned about half of men's salaries, interrupted or part-time employment, and the fact that pensions have typically not been treated as joint assets when a marriage breaks down or a partner dies.

Other factors which impinge on women's programs are more directly related to the alcohol field. Women receive mixed messages about alcohol use. Since there continues to be disapproval of drinking and drunkenness, the resulting social stigma can, in a negative way, prevent women from abusing alcohol. At the same time, the alcohol industry in Canada is judged to be increasingly directing its advertising and promotional efforts to young women. As alcohol sales level off, the brewers, distillers, and vintners are spending approximately $200 million annually to retain and expand the market. Neither situation is useful or acceptable but serves to point out the absence of appropriate societal attitudes and public policy which could benefit women.

It must also be acknowledged that the issue of women and alcohol is not a priority for agencies responsible for prevention and treatment programs. This has meant scarce financial and human resources. It is reflected in the fact women have found it difficult to promote adequately and use the pamphlet *It's Just Your Nerves*, because the topic was not considered part of their employing agency's mandate. In fact, a new agency, Amethyst, had to be created to treat women alcoholics rather than evolve from existing community services in the face of recognized special needs of women.

Concern about women and alcohol rose rapidly in the middle and late 1970s. The concern was evidenced by many articles, and demands for increased research and services. The momentum has not been maintained, and the numbers of programs and the recommendations for research remain much the same as they were a few years ago. The exception is the issue of fetal alcohol syndrome (FAS) which has probably generated more research and publications than any other related issue. Ironically, FAS seems to have diverted attention from the hard-won focus on women as women to the traditional focus on women as mothers.

Future approaches

This article has outlined current educational approaches related to women and alcohol and some of the issues which affect program development. If future educational approaches are not to be severely limited by the environmental factors outlined here, and many more which have not been mentioned, then women must become skilled in the art of social as well as personal change. Somehow new systemic approaches must be developed which will link political, social, and individual efforts in enhancing and maintaining health.

The following are three critical concerns to be considered in the development of future programs:

- An information base is necessary to allow for development of increasingly effective programs. This means that research is needed to determine the special characteristics of women's drinking, that the social and cultural influences on women's drinking should be examined including content analysis of media messages; and that programs should be evaluated for their effects and the results widely disseminated.
- Specific education programs should be one aspect of multi-faceted strategies which include policy and research development, public information, and professional education. Long-term and multi-faceted strategic efforts are required as too many forces compete against the single tactic.
- Specific education programs should be designed to empower women to change their lives and their environment. They should be based on what women want and need to know to build on existing strengths as well as to develop new skills and knowledge. A basic skill is the capacity to work collectively to overcome disadvantages.

Finally, it should be stated that, after nearly 10 years, the development of Canadian education programs in the field of women and alcohol is positive and ongoing, despite obstacles. The programs described in this paper have been milestones; the experience is being translated into improved efforts on the part of women committed to personal and social change.

Bibliography

Aries, E. Interaction Patterns and Themes of Male, Female and Mixed Sex Groups, *Small Group Behaviour*, 7(1), 1976. p 7-18

Badiet, P. Women and Legal Drugs: A Review. In A. MacLennan (Ed) *Women: Their Use of Alcohol and Other Legal Drugs*, Toronto: Addiction Research Foundation Books, 1976. p 56-81

Beckman, L.J. Alcoholism Problems and Women: An Overview. In M. Greenblatt and M.A. Schuckit (Eds) *Alcoholism Problems in Women and Children*, New York: Grune and Stratton, 1976. p 65-97

Canadian Foundation on Alcohol and Drug Dependencies. The National Consultation on Alcohol and Drug Abuse Among Women, August 16-17, 1975.

Carver, V., Huneault, N. and Pinder, L. *Characteristics, Service Patterns and Needs of Female Alcoholics in Ottawa-Carleton*. A survey conducted by the Task Group on Women and Chemical Dependency, Ottawa, 1976.

Carver, V. et al. *Task Group on Women and Chemical Dependency: A Community Action and Research Project*. Paper presented at the 12th Annual Conference of the Canadian Foundation on Alcohol and Drug Dependencies, Winnipeg, July, 1977.

Carver, V., MacGregor B. and Steffans C. *Amethyst Women's Addiction Centre: Final Report*, Ottawa, February, 1984.

Cooperstock, R. Sex Differences in the Mood-Modifying Drugs, An Explanatory Model, *Journal of Health and Social Behaviour*, 12, 1971. p 238-244

Cooperstock, R. Psychotropic Drug Use Among Women, *Canadian Medical Association Journal*, 115. 1976. p 760-763

Currie, J. *Skills, Sharing and Support, An Evaluation of the Women's Self Help Network*, Northern Vancouver Island, October, 1983.

Economic Council of Canada. *On the Mend*. 20th Annual Review, 1983.

Emrick, C.D. A review of Psychologically Oriented Treatment of Alcoholism: 1. The Use and Interrelationships of Outcome Criteria and Drinking Behaviour Following Treatment, *Quarterly Journal of Studies in Alcohol*, 35, 1974. p 523-549

Evalusearch. *Results of a Survey of Trained Facilitators of the "It's Just Your Nerves" Resource*, July, 1983.

Ferrence, R.G. Sex Differences in the Prevalence of Problem Drinking. In O.J. Kalant (Ed) *Alcohol and Drug Problems in Women*, Volume 5, New York and London: Plenum Press, 1980. p 69-119

Gomberg, E. Alcoholism in Women. In B. Kissir and H. Begleiter (Eds) *Social Aspects of Alcoholism*. New York: Plenum Press.

Health and Welfare Canada. *Alcohol in Canada: A National Perspective*. Ottawa, 1984.

Homiller, J.D. Sex Bias in Alcoholism Research, *Focus on Alcohol and Drug Issues*, 1(11), 1978. p 28-29

Kickbusch, I. Involvement in Health: A Social Concept of Health Education, *International Journal of Health Education*, 1981. p 24(4)

Kintner, S. *So What's So Different About Women Who Drink?* Wheeler Clinic, Inc, The Central Connecticut Community Mental Health Affiliates, Inc, 1976.

Labour Canada Women's Bureau. Part I — Participation. DSS Cat No L38-30/1983-1.

Lindbeck, V.L. The Woman Alcoholic: A Review of the Literature, *International Journal of the Addictions*, 7(3), 1972 p 567-580

Lisansky, E.S. Alcoholism in Women: Social and Psychological Concomitants. *Quarterly Journal of Studies on Alcohol*. 18, 1957. p 588-632

MacLennan, A. (Ed) *Women: Their Use of Alcohol and Other Legal Drugs*. Toronto: Addiction Research Foundation, 1976.

MacLeod, L. *Wife Battering in Canada: The Vicious Circle*. Ottawa: Government of Canada, January, 1980.

Mandel, L.L. and North S., Sex Roles, Sexuality and the Recovering Woman Alcoholic: Program Issues, *Journal of Psychoactive Drugs*, 14(1-2); 1982. p 163-166

Mercier, C. *C'est pas grave, c'est rien que vos nerfs, Evaluation Report*, July, 1983.

Nadeau, L. *Women's Issues in the Therapeutic Community: Patriarchy and Male Protection as Counter Therapeutic*. Paper presented at the World Conference on Therapeutic Communities, Montreal, 1976.

Nadeau, L. *Women and Alcohol: The Epidemiological Data, the Influence of Work, the Inheritance of Alcoholism and the Fetal Alcohol Syndrome*. Paper presented at the "It's Just Your Nerves" Forum, Saskatoon, February, 1983.

Naegele, B.E. The Prevalence of Alcoholism Among Canadian Women. *International Journal of Mental Health*, 11(1-2), 1982. p 67-76

National Institute on Alcohol Abuse and Alcoholism. *Advances in Alcoholism Treatment Services for Women*. Rockville, Maryland, 1983.

Paltiel, F.L. *Notes on Recent Initiatives In Canada* for presentation at expert meeting on Social Security, Taxation and General Welfare measures. OECD, Paris, September, 1983.

Sandmaier, M. Women Helping Women: Opening the Door to Treatment, *Alcohol Health and Research World*, Fall, 1977. p 17-23

Schuckit, M. The Alcoholic Woman: A literature review, *Psychiatry in Medicine*, 3(1); 1972. p 37-43

Shultz, A. *Radical Feminism: A Treatment Modality for Addicted Women*. Presented at the National Drug Abuse conference panel on Special Concerns of Women, Chicago, 1974.

Statistics Canada. Income Distribution by size in Canada, Preliminary Estimates, Cat No 13-206, Annual Statistics Canada, 1982.

Wilsnack, S.C. Prevention of Alcohol Problems in Women: Current Status, *Alcohol Health and Research World*, Fall, 1978. p 23-31

Woodrow-Marvin, M. *Women and Drugs: Annotated Bibliography*. Health and Welfare Canada, 1975.

NEWS AND COMMENT

Home environment important

Fathers-to-be should cut back on alcohol

ATHENS — Fathers-to-be should follow the example of women who reduce their drinking during pregnancy, says a Swedish associate professor of psychiatry.

Gunnilla Larsson, MD, of Huddinge University Hospital, Huddinge, Sweden, says studies have shown children of alcoholic parents often experience lack of environmental stability.

A survey in Sweden showed "pregnancy in particular appears to motivate women to reduce their alcohol consumption," Dr Larsson said. "The desire to have a healthy baby is a powerful force and most mothers reported abstinence during pregnancy."

However, "the male partners of the women were not as motivated to reduce their alcohol consumption as the women," Dr Larsson told the 30th International Institute on the Prevention and Treatment of Alcoholism here.

This could contribute to "a risk for maternal relapses as well as an unsatisfactory home environment for the child after birth."

Education through the mass media and from health officials seems to have affected attitudes of parents in Sweden, Dr Larsson says.

She says nurses at various clinics talk about alcohol individually with parents, then they visit when the child is nine months old and inform parents about the increasing risk of child accidents when parents are intoxicated.

"In an inquiry study one year after the alcohol information, 25% of the mothers and 17% of the fathers stated they had reduced their alcohol intake."

Dr Larsson says fetal alcohol syndrome (FAS) has become a high-profile issue in Sweden. The majority of pregnant women and parents attend clinics, and staff there can play "a crucial part" in education on alcohol abuse.

"The information during the last couple of years . . . concerning the risk of alcohol-induced damage to the fetus has had a considerable impact on the mothers, and many of them had discontinued drinking already when they were planning to have a baby."

Swedish politicians have also considered enforcing laboratory screening of all pregnant women to detect who is at risk for FAS. However, studies on this kind of screening show it wasn't sensitive enough, Dr Larsson adds.

Curbs urged on drug producers

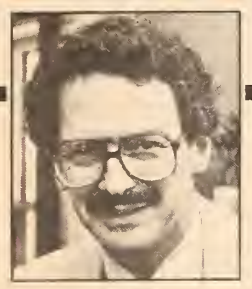
WASHINGTON — Diplomatic screws must be tightened even more in drug producing countries if the flow of drugs to the United States is to be curbed, members of a Congressional committee have declared.

A report by the House of Representatives select committee on narcotic abuse and control, headed by Democratic Representative Charles Rangel, said production in most producer countries has increased despite US counter-efforts. Representative Rangel said the government must enforce legislation passed last year which requires the president to suspend economic and military aid to countries not taking steps to eradicate drug crops.

The report was prepared following extensive visits by committee members to both South America and Asia.

It said large amounts of heroin are entering the US from Pakistan, Thailand, Italy, and Mexico.

About 75% of cocaine comes from Colombia, manufactured from coca paste smuggled there from Peru and Bolivia. Up to 60,000 tons of marijuana enters the US yearly from Colombia, Jamaica, and Mexico; about 2,000 tons is grown domestically.



GILBERT

'Scientists have much to learn from journalists . . .'

Journalistic practice

By Richard Gilbert

This month I was going to write about a new analysis that casts grave doubts on the notion that moderate alcohol consumption is good for your heart. Instead, prompted by some media treatment of last month's column, I'm going to return to a matter I last discussed in December, 1982 — science and journalism.

The central point in that first column on science and journalism was that "journalists and scientists have a lot more in common than most people realize." This point had been elaborated in an article by Robert McCall and Holly Stocking about scientists' antagonisms toward the media.

As both an occasional scientist (I sometimes do things that pass for research) and an occasional journalist (I write to deadlines and get paid for it), McCall and Stocking's article helped me some way toward resolving my confusion on the matter.

My interest in how scientists feel about journalists, and my confusion, were revived at breakfast on July 6 when a story on the front page of the Metro section of the *Globe and Mail* looked at first sight as though it had been lifted without attribution from my last column, which had appeared a few days earlier (**The Journal**, July).

The thesis of my column was "what is hurting tobacco growers as much as price hikes and politicking is the diminishing use of tobacco in cigarettes." To my best knowledge, this was a novel if modest notion, arrived at after some analysis of the tobacco-growing and cigarette-manufacturing businesses, tempered with understanding of trends in cigarette use and their causes.

The thesis of the *Globe and Mail* story was that "Canadian cigarette manufacturers are reducing the amount of tobacco in most cigarettes and it's hurting tobacco growers who already face a reduced crop because of falling consumer demand." The story was written with the confidence of someone who had arrived at a novel if modest conclusion after some analysis of the tobacco-growing and cigarette-manufacturing businesses, tempered with understanding of trends in cigarette use and their causes.

Piqued

I read through the *Globe* piece again, in the unlikely event I had missed my name or a reference to **The Journal**. (Like most politicians, I can usually spot my name in newspaper text from a distance of 20 feet.)

Further scrutiny, however, revealed no mention of me or **The Journal**. A little piqued that the *Globe* might borrow my work and represent it as its own, I called the reporter, Dorothy Lipovenko. She said she had got the idea (that cigarette manufacturing practices might be affecting tobacco growers) from reading my article, and decided to write a piece on the same topic. She had telephoned me about my article but had failed to reach me. Not having spoken with me, she did not feel the need to mention me or **The Journal** in her article.

Ms Lipovenko said she had called the two tobacco industry sources cited in my article herself and secured the information she needed.

I called a veteran medical reporter I respect and asked her if she felt something was amiss. The answer I got was a qualified no. This veteran reporter would invariably give attribution, but, because Dorothy Lipovenko had made her own phone calls, she could not necessarily be faulted.

The notion that cigarette manufacturing practices have hurt tobacco growers is no great revelation, and it is not particularly scientific in nature. Thus, this is perhaps not the best incident from which to generalize about scientists and journalists. Nevertheless, what happened has taught me a little more about the perspectives of scientists and journalists than I knew when I embraced McCall and Stocking's views about their similarities in my earlier column — and it seems a good enough time to expand on that discussion and on some of the differences.

Ideas and evidence

The essential differences, I believe, concern the role of ideas and the nature of evidence. McCall and Stocking had noted that "journalists don't use books — they use the telephone." What medical and scientific reporters do, as I understand the process, is report a new theory, notion, dispute, or finding they consider important or newsworthy, and then call recognizable experts for opinion on the matter and its meaning. All this may be done under enormous time pressure, both to meet editors' demands for stories and to beat the competition.

For journalists, quotes from interviews conducted with recognizable experts are as important as anything in a story. Such quotes give immediacy to what journalists write, an immediacy that is very appealing to readers. The quotes create the impression and reflect the reality that a journalist has gone, on behalf of the reader, to the front line or moving edge of the process of discovery. Collection from experts of responses to and interpretations of an issue or development are a journalist's original contribution.

I should have been less surprised by the *Globe* article. My work had led to a reasonable conjecture about the plight of tobacco growers. Once expressed, the conjecture was in the public domain. The origin of the conjecture was of no more interest than if it had been heard in a cab, except to the extent that the author of the conjecture might be a fertile source of quotes.

An analogy would be a journalist coming across a report of research on the relation between alcohol problems and the number of places at which alcohol can be consumed, such as the paper by Jerome Rabow and Ronald K. Watts in the July, 1982 issue of the *Journal of Studies on Alcohol*. The journalist is not able to reach the authors, but he is able to work out from their article whom best to phone and what questions to ask.

A story duly appears under the title, Liquor licensing causes alcohol problems. The lead interview is with a drinking driver awaiting trial who asserts that he would not have hit the tree if the restaurant had not been allowed to serve him wine. Experts on drinking, driving, and related matters are also quoted in support of what is now the journalist's thesis. They were asked specifically about the validity and meaning of Rabow and Watts' study, but they are quoted as buttressing the reporter's conclusion.

This illustrates a basic difference between the attitudes of scientists and journalists to the evolution of thinking about an issue. Scientists are concerned to acknowledge the provenance of their work, not only in the sense that Isaac Newton did it — "If I have been able to see farther than others it is because I stood on the shoulders of giants" — but also because such acknowledgement brings order to a discipline and weight to an exposition.

Rabow and Watts began their paper by describing the score or so items of previous work that gave them the idea for their study. Readers get a good sense of where the author's hypotheses came from; their understanding of the results of the study is enhanced accordingly.

Journalists, on the other hand, are concerned with writing a good story, ie, a story that captures the reader long enough for the "news" to be conveyed. This also means writing an accurate story, but accuracy here may mean no more than getting the quotes right. Where the story came from is important only as far as it adds to the reader's interest.

Medieval and democratic truths

This difference was described in a different way in a recent article in the *Globe and Mail* by science writer Stephen Strauss entitled: Scientists, writers differ on 'truths.' Strauss quoted Bernard Cinader, University of Toronto immunologist, as saying that newspapers have an "ideological, medieval sense of truth," whereas "things have a validity only for a certain period of time in science." Albert Einstein said: "No amount of experimentation can ever prove me right; a single experiment can prove me wrong."

The scientific conception of truth and correctness is essentially democratic. A simple majority does not determine the fate of leading ideas, but such ideas are certainly subject to recall in the way that believers in medieval truths would find disturbing.

Another difference between scientists and journalists concerns what counts as relevant data with which to tell a story or buttress an argument. For scientists these are almost exclusively their own measurements, and those of other scientists already on record. For the journalist, as noted above, the relevant data are well-chosen quotes commenting on the event or development.

None of this is to disparage the work of journalists. It is simply to qualify my earlier comments about the similarities between scientists and journalists, and perhaps to add a little to our understanding of why people with scientific backgrounds get upset by journalistic practice.

I wrote then that ". . . to some extent, journalism makes science possible in our society . . . by glamorizing, or at least making available to a wide range of people, what is most often a very dull and unprofitable activity, and thereby helping to ensure continued funding." The fact that journalists and scientists have very different techniques for developing and communicating information should not be surprising.

Scientists have much to learn from journalists. Ontario-born Sir William Osler, once described as "the most influential physician in history," advised his readers: "In science the credit goes to the man who convinces the world, not to the man to whom the idea first occurs." Journalists are more influential than scientists because they are better equipped to convince the world.

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Editor... Letters to the Editor...

Abstinence principle promoted

WCTU celebrates 100 years

This year, the Canadian Woman's Christian Temperance Union celebrates 100 years of continuous commitment to challenging each generation to higher standards of morality.

We have promoted the principle of voluntary total abstinence from alcoholic beverages and from the non-medical use of addicting drugs, particularly through youth programs in schools and churches.

Our 100th Canadian Convention is meeting August 20 to 24 at the Ontario Bible College, 25 Ballyconnor Court, Willowdale, Ontario, and visitors are invited to attend.

Mrs A. H. Rawlins
Canadian President
Woman's Christian Temperance Union
Woodstock, Ont.

Poster for teens sparks interest

On page 11 of the May issue of **The Journal** there was an article entitled, Teens prefer hard-hitting DWI slogan.

I would like to acquire some of these posters for use in North Platte High School's early-intervention program. Please send me the address of the Insurance Bureau of Canada so I may contact them.

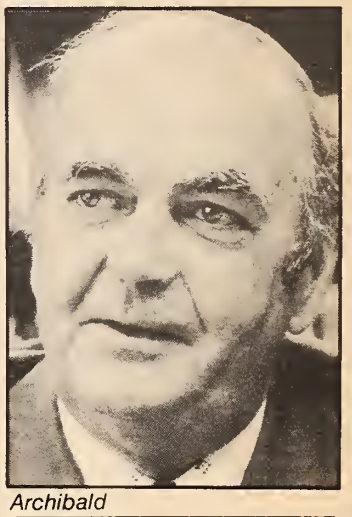
Ivan Kershner
Vice-principal
North Platte Schools,
North Platte, Nebraska

Address is: 181 University Ave, 13th fl, Toronto, Ont, Canada M5H 3M7

Editorial Advisory Board

Archibald appointed international adviser

The Journal is pleased to announce that H. David Archibald, chairman of the Editorial Advisory Board since 1976, has agreed to serve as the board's Senior International Adviser following his recent retirement as its chairman.


Archibald

Mr Archibald, founder and director of the Addiction Research Foundation (ARF) for more than 25 years, will continue to consult with the board, editor, and staff of **The Journal**.

Mr Archibald, who retired from the ARF in 1983, is president of the International Council on Alcohol and Addictions, based in Switzerland, and is also commissioner of Bermuda's Royal Commission into the Use and Misuse of Illicit Drugs and Alcohol.

Senator Lorna Marsden, a board member since 1978, has been named acting chairman. Dr Marsden was appointed to the Senate of Canada in January. Prior to that, she was a vice provost at the University of Toronto (U of T).

Joining the board at its June meeting was Dr Mary Jane Ashley, chairman and professor, department of preventive medicine and biostatistics, faculty of medicine, U of T.

Other recent appointments are Ron Draper, director-general, Health Promotion Directorate, Health Services and Promotion branch, Health and Welfare Canada, and Dr Wolfgang Schmidt, head of epidemiology at the ARF.

Retiring from the board are Richard Anthony, a lawyer with the ministry of the attorney general in British Columbia, and Dr Helen Nowlis, retired director of the now defunct Alcohol and Drug Abuse Education Program, Office of Education, of the then United States Department of Health, Education and Welfare, in Washington, DC.


Marsden


Draper


Schmidt

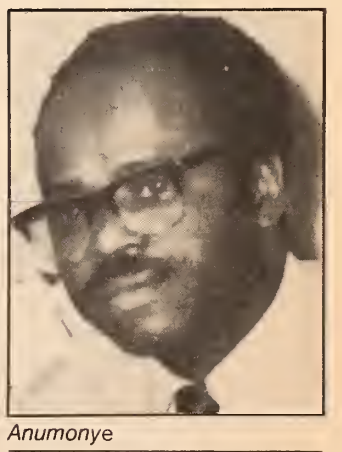

Ashley

Professor Amechi Anumonye, MD, an overseas corresponding member of The Journal's Editorial Advisory Board since 1977, was killed in an automobile accident last winter in Nigeria.

Dr Anumonye, one of Africa's leading psychiatrists, was also interested in the health and social problems related to alcohol and drug abuse and had published numerous articles and books on the various aspects of substance abuse.

A member of the International Council on Alcohol and Addictions (ICAA), Lausanne, Switzerland, since the early 1970s, Dr Anumonye was a member of the ICAA board from 1978 to 1982 and initiated the first African Seminar on Drug Dependence in Lagos in 1979.

At the time of his death, Dr Anumonye was professor of psychiatry, University of Lagos Medical School. He was a former director of psychiatry at the Medical College of New Jersey.


Anumonye

Born in Nigeria in 1931, he was educated in Nigeria, the United Kingdom, and the United States.

Drugs and the law

Police powers of arrest, search, and seizure

By Robert Solomon and Sharyn Langdon*

Section 1 — The Origins of Canadian Drug Enforcement Laws

Since the first federal drug law was enacted in 1908, the police have attributed the growth of the illicit drug trade to drug users' cunning, the shortage of police resources, courts' leniency, and deficiencies in the law, particularly the lack of adequate police powers. During the last 75 years, police and government officials responsible for drug enforcement have successfully lobbied Parliament for special statutory powers. Consequently, police have broader powers in even a minor drug case, such as simple possession of cannabis, than they have in an investigation for murder, arson, or some other serious criminal offence.

Most of these special powers were enacted during the 1920s following a campaign to depict addicts as fiendish criminals obsessed with a need to addict others. Canada's addict population was predominantly Chinese and relatively small, and the public had little direct contact with, or objective information about, drug users. For the most part, Canadian courts shared Parliament's sympathy for narcotic enforcement officials and broadly interpreted these special powers.

Until the mid-1960s, the federal drug law was enforced almost exclusively by Royal Canadian Mounted Police (RCMP) drug squads. The annual number of convictions rarely exceeded 500, and all but a small fraction of the charges involved opiates. The dramatic increase in cannabis use in the last 18 years has prompted a parallel increase in enforcement activities. Scores of municipal, provincial, and RCMP officers now invoke the special drug enforcement powers daily; and the targets of these powers are drawn almost exclusively from Canada's population of roughly four million cannabis users. As the number of people subjected to the special enforcement powers increased, so did the complaints and controversies surrounding their use. Few aspects of Canadian drug policy have generated such heated debate. Viewed by critics as wholly unwarranted intrusions on civil liberties, these same powers have been steadfastly defended as an essential tool in the fight against the illicit drug trade.

The purpose of this article is to outline the nature of these drug enforcement powers.

Section 2 — Introduction

The Narcotic Control Act (NCA) and the Food and Drugs Act (FDA) both contain special powers of search and seizure, but make no reference to arrest powers. As indicated earlier (**The Journal**, July) there is a federal law which applies the Criminal Code's procedural provisions, including those relating to arrest, to other federal statutes. Consequently, an officer's authority to search for and seize drugs is contained in the NCA and the FDA, but his power to arrest is governed by the Criminal Code's general arrest sections.

It should be noted that all police, regardless of the police force that employs them or regardless of their assigned task, have authority to enforce both federal and provincial laws. In appropriate circumstances, an officer may use all his enforcement powers under the Criminal Code, other federal statutes, and provincial legislation in a single investigation. For example, the Ontario highway traffic law permits an officer to stop any vehicle at random to determine if the driver has been drinking. If, in the course of this incident, the officer detects the odor of cannabis, he may use the special search powers of the NCA to search the vehicle and all occupants. Should the officer find illicit drugs, he may lay a drug charge in addition to any other relevant charge.

Section 3 — Police Powers of Arrest

Police officers may arrest a suspect if they have a warrant for his arrest. Even if the suspect is not the person named in the warrant, the officers' conduct is legal provided they have reasonable and probable grounds to believe that they are arresting the wanted person. However, in most drug cases, the police make a decision based on their own observations at the scene and arrest the suspect without a warrant, pursuant to Section 450 of the Criminal Code.

(a) Section 450 of the Criminal Code

Section 450 allows the police to arrest a person if they have reasonable and probable grounds to believe that he has committed, is about to commit, or is committing a drug offence. Even if the officers are wrong, their conduct is lawful provided it is based on reasonable and probable grounds. It must be emphasized that a suspect is required to submit to a lawful arrest, even if he is innocent of any wrongdoing.

Whether an arrest is lawful often depends on whether the police had reasonable and probable grounds. To determine this, the courts ask whether the facts were sufficient to cause a reasonable man to have a strong and honest belief in the suspect's guilt. Mere suspicion is not enough. For example, the suspect's prior criminal record by itself does not constitute reasonable and probable grounds. An officer must approach the issue with an open mind, make a reasonable investigation, and listen to the suspect's and witnesses' explanations. Having completed the initial investigation, an officer must consider the facts, decide on the charge, and then arrest the suspect for that offence.

(b) Police Powers and Obligations in the Arrest Process

The law defines not only the criteria for a lawful arrest, but also the way in which the arrest must be made. Even if there are grounds to make a legal arrest, the officer must properly exercise his powers in the remainder of the arrest process.

A police officer must inform a person of the reason for the arrest at the time of the arrest, unless the reason is obvious, or the suspect is fleeing, resisting, or incapable of understanding the explanation. In any event, the officer is still obliged to disclose the reason as soon as possible. The Canadian Charter of Rights and Freedoms has imposed an additional obligation upon police to inform suspects of their right to contact a lawyer without delay.

The law also defines the circumstances in which an officer is entitled to use force. Except in highly unusual circumstances, the suspect must be given an opportunity to submit peacefully. Even if the suspect resists, the officer may use only reasonable force in subduing the suspect and making the arrest. An officer can only use deadly force in self-defence, to protect someone else from serious injury or death, or to prevent the escape of a fleeing supect who cannot be stopped in a less violent manner. It is a criminal offence for an officer to use excessive or unnecessary force.

Once the police have lawfully arrested the suspect, they have the right to search him, his personal belongings, and the area within his immediate control for evidence of the offence or a weapon.

(c) A Suspect's Rights and Obligations in the Arrest Process

Canadian law makes a fundamental distinction between a suspect's rights before and after an arrest. Until a person has been arrested, he is generally under no legal obligation to assist or cooperate with the police. Except in a limited number of cases, suspects may refuse to identify themselves, account for their presence, answer questions, remain at the scene, accompany an officer, or submit to a search. Basically, individuals are free to go their own way until they have been lawfully arrested. A suspect's assertion of his right to be left alone does not constitute a criminal offence or, in itself, provide an officer with reasonable and probable grounds to make an arrest.

However, once lawfully arrested, a person must submit peacefully. If a suspect resists or flees, he may be charged with one of several independent criminal offences, such as obstructing or assaulting an officer, resisting arrest, or escaping lawful custody. Remember that an officer only needs reasonable and probable grounds to make a lawful arrest, and a suspect must submit peacefully even if innocent.

In their efforts to facilitate enforcement, our courts have not required officers engaged in drug enforcement to follow the normal arrest procedures. Perhaps this is best illustrated by the 1949 Ontario Court of Appeal decision in **Regina v Brezack.** In that case, two officers grabbed Brezack by the throat and arms from behind without warning and, when one of the officers forcibly attempted to search Brezack's mouth for drugs, he struck the officer and bit his finger. Brezack was convicted of assaulting a peace officer in the lawful execution of his duty even though the police accosted him without identifying themselves, making a formal arrest, notifying him of the reasons, or allowing him to submit peacefully. While recognizing that these police tactics fell far short of traditional arrest procedures, the Court concluded that such drastic measures were necessary when dealing with drug users.

Section 4 — Police Powers of Search and Seizure in Drug Cases

Police officers in drug investigations have virtually unequalled powers to search private premises. First, they have powers to search under several sections of the Criminal Code, other federal statutes, and provincial legislation. Secondly, they have special powers of search and seizure under the two federal drug Acts.

(a) The Criminal Code's Search Warrant Provisions

Although these provisions do not apply to drug searches, they provide a basis of comparison with the drug Acts. The Criminal Code authorizes a judicial officer to issue a search warrant based upon information given under oath. The judicial officer must be satisfied that there are reasonable grounds to believe that the specified premises contain anything relating to a Criminal Code offence, anything that will provide evidence of a Code offence, or anything that is intended to be used in a serious offence involving injury to a person. An application for a search warrant must clearly set out the grounds for the officer's belief, the articles to be seized, the place to be searched, and the offence to which the evidence relates.

Unless otherwise provided, the search warrant can only be executed during the day. Officers must have the search warrant with them at the time of the search. Except in unusual circumstances, the officers must show it to the occupant and request entry before using force. The search warrant provides authority to search only the premises, not its occupants. Any articles the police seize must be brought before a judicial officer and are usually held until the criminal proceedings are over.

(b) The Federal Drug Acts' Special Search Provisions

The NCA and the FDA extend police search powers in drug cases beyond the bounds of the Criminal Code.

Unlike the Code, the federal drug Acts specifically distinguish between dwelling-houses and other private premises. A dwelling-house is any place where people live, such as a private home, apartment, hotel room, or a student's room in a university residence.

(i) The Search of Premises other than Dwelling-Houses

The NCA and the FDA authorize police to search without a warrant, day or night, any place other than a dwelling-house in which they reasonably believe there is an illegal drug. The Acts give the police the power to act on their own initiative. The officer is not required to seek judicial approval either before or after the search is made.

These special provisions of the drug Acts also allow the police to search any person found in the searched premises. The police do not need to have any evidence, belief, or suspicion that an occupant is violating the drug law, or for that matter, any law. An occupant is required to submit to a search in these circumstances, despite the fact that he has not been arrested.

In carrying out a drug search, the police are authorized to break in doors, ceilings, floors, containers, and other similar objects. They may seize illicit drugs and anything they suspect was used in, or provides evidence of, the offence. This might include scales, address books, drug paraphernalia, and money.

A convicted drug offender's money and drugs are subject to forfeiture. Under the NCA, a person convicted of possession for the purpose of trafficking, trafficking, importing, or exporting may also have the car, boat, or plane in which the drugs were carried, seized, and forfeited.

(ii) The Search of Dwelling-Houses

The federal drug Acts contain two separate provisions

→

*This article is the second of an occasional series (The Journal, July) and is based on a chapter of a booklet entitled *Canadian Alcohol and Drug Laws*, to be published by the Addiction Research Foundation.

Solomon

Langdon

The Journal, Addiction Research Foundation, 33 Russell St, Toronto, Canada, M5S 2S1

BACKGROUNDER

(from page 9)

for searching dwelling-houses, namely special search warrants and writs of assistance. Both Acts provide that a judicial officer may issue a search warrant if he is satisified by information given under oath that there are reasonable grounds for believing that a dwelling-house contains illicit drugs. Unlike search warrants issued under the Criminal Code, these special warrants can be executed day or night and authorize the search of a dwelling's occupants.

The writs of assistance are perhaps the most controversial feature of the special drug enforcement powers. As mentioned, the police can generally enter a dwelling only if they have a valid search warrant issued by a judicial officer. This judicial review of the police evidence and control over the issuing of search warrants is designed to protect the homeowner's privacy. However, the writ of assistance is a continuing blanket search power which authorizes officers to enter day or night and search any dwelling-house without a warrant, if they reasonably believe that it contains illegal drugs. In order to prevent the possible destruction of evidence, the courts have permitted the police to break in without giving notice, using as much force as necessary.

Although Federal Court judges issue writs of assistance, they have no control over the granting or use of the writs. Once the federal Attorney-General applies for a writ on behalf of an officer, the judge must issue it to that person. The writ is not limited as to time or place and is valid for the officer's entire career. The judge who issues the writ has no authority over when, where, how often, or in what circumstances it is used. Judges themselves, as well as other legal professionals, have criticized the broad powers that the writs give to the police.

With the enactment of the Charter, the courts have been confronted with the issue of whether the writs violate an individual's constitutional rights and freedoms. The federal government has recently introduced amendments to the NCA and the FDA which would abolish the writs. However, at the same time, the government has proposed creating what are known as "telewarrants." If passed, this amendment would permit the police to apply for a search warrant over the telephone in special circumstances when they need to act quickly. At least, a judicial officer would still be required to assess the police information and to decide whether to authorize the search.

(c) Police Methods of Enforcement

Police face special problems in attempting to enforce drug laws. In most criminal cases, there is a victim who contacts the police and provides information. Except in rare circumstances, there is no victim in drug cases. For example, both the buyer and seller of marijuana are willing participants and try to keep their activities hidden from the police. The fact that drugs can be easily disposed of makes detection even harder.

The Canadian courts have accepted that the police will have to use unusual and aggressive enforcement techniques in drug cases. This includes the police use of paid informants, wiretaps, undercover police officers, surprise raids, trained dogs, strip searches of suspects, and the granting of immunity to some suspects in return for information about other suspects. As illustrated in the **Brezack** case, the police have also been permitted to grab suspects by the throat without warning, in an effort to prevent them from swallowing any drugs that they might have in their mouths.

The courts view most drug offences as serious crimes and have been supportive of police engaged in drug enforcement. This general attitude is clearly reflected in a recent Supreme Court of Canada decision which involved police trickery in obtaining a confession from a suspected drug trafficker.

Mr Justice Lamer stated: "It must be borne in mind that the investigation of crime and the detection of criminals is not a game to be governed by the Marquess of Queensbury rules. The authorities, in dealing with shrewd and often sophisticated criminals, must sometimes of necessity resort to tricks and other forms of deceit and should not through (the rule concerning the admissibility of confessions) be hampered in their work. What should be repressed vigorously is conduct on their part that shocks the community . . . but, generally speaking, pretending to be a hard drug addict to break a drug ring would not shock the community; nor would, as in this case, pretending to be a truck driver to secure the conviction of a trafficker; in fact, what would shock the community would be preventing the police from resorting to such a trick."

Section 5 — Conclusion

During the past 75 years, Parliament has created sweeping drug enforcement powers which are far more extensive than the general enforcement provisions of the Criminal Code. For their part, the Canadian courts have broadly interpreted police authority in drug cases and have given officers a relatively free hand in exercising these powers. The enactment of the Charter will likely induce the courts and Parliament to reconsider their approach.

At least some of the statutory search powers and tactics used in enforcing drug laws will likely be limited or struck down under the Charter. Perhaps more importantly, the Charter provides, for the first time, a public forum in which the nature of these police powers and practices will be discussed. Regardless of its outcome, a challenge focuses attention in open court on whether an individual's constitutionally-guaranteed rights and freedoms have been violated. The changes in police and prosecutorial practices adopted to avoid constitutional challenges may have a more profound effect in safeguarding rights than the successful court challenges. In a similar vein, the Charter may induce Parliament and the provincial legislatures to amend existing legislation and to consider carefully the question of individual rights in drafting future statutes.

COMMENT

Is Canadian drug law truly this repressive?

By Arnold S. Trebach *

Two visits to Vancouver, British Columbia, the breathtakingly beautiful province in western Canada, do not make me an expert on drug abuse control throughout the country. Yet, I saw enough there to form the initial impression that many Canadian judges and police leaders view brutal repression of drug users, especially heroin addicts, as morally and legally justified.

Even that initial impression is shocking to me. I have spent more than a decade criticizing the excesses of drug abuse control in my own country, the United States. Persistently, I have urged US reforms in line with the British model under which addicts and doctors are allowed a good deal of humanizing privacy — and wherein narcotics are "medicalized" for the purposes of addict treatment (**The Journal**, May). My assumption was that the Canadians would be very much like the British. I found no evidence to support that assumption.

The evidence I did find leads me to want to utter a prayer for the addicts of BC, which contains perhaps the majority of the narcotic addicts of Canada. Their fate seems to provide a vision of the US system gone mad.

Addicts and their families live in fear — fear of police violence on the street, fear of what would be considered by US law to be "random" searches of their homes, and fear that in the course of police assaults and break-ins, their children or parents will be harmed.

What is worse, they seem to accept their fate as part of the natural order of things. If you are an addict, this is how you are treated, and there is nothing that can be done about it: "Please don't use my name because the police told us that if we complained, they would be back and 'find' illegal drugs in our house."

The atmosphere of repression in BC compares to nothing I have seen or felt except when I was a US civil rights official investigating police brutality to blacks in Mississippi and Alabama.

A relatively few addicts are provided a minimum supply of oral methadone by BC doctors. The police keep these doctors on a tight rein and recently brought charges against several of those who had been prominent in addict care (**The Journa**l, July). Most addicts in the province must buy their drugs on the black market. It's no surprise that many addicts engage in crime to support their habits.

Some now taking methadone find that this drug simply does not agree with them. They claim they can function normally on heroin or the legal drug Dilaudid (hydromorphone). But Canadian law, following the irrational US example, allows neither of the latter drugs in addiction treatment.

Even more disturbing, major Canadian laws and leading Supreme Court decisions support virtually uncontrolled police power and a mean view of the rights of citizens. My 33 years as a lawyer had led me to believe that such legal doctrines had long ago been tossed in the dustbin of history.

Recently, the Canadian Supreme Court approved the conviction of Vancouver hairdresser Victor Amato for cocaine trafficking, even though the evidence made it clear that he had not been a dealer or a user and that he had provided the cocaine only after undercover RCMP officers (Royal Canadian Mounted Police) had harassed and threatened him for three months. By US legal standards, this would have been an outrageous case of entrapment. However, entrapment is not even clearly recognized as a defence in Canadian law.

Neither is the notion, established in 1962 by the US Supreme Court, that it is illegal to penalize a person for the status of being an addict. Along with the Amato case, however, the Canadian Supreme Court upheld the validity of a BC law that provided for the compulsory "treatment" of heroin addicts in a closed institution. As luck would have it, however, the province never implemented the Orwellian scheme.

Evidence seized in the most violent manner is, in most cases, allowed in evidence. It is judicially approved practice for police officers to approach addicts on the streets, seize them by the throat, and forcefully prevent them from swallowing the small "bundle" of

Trebach

drug capsules they often carry in a balloon in their mouths as a means of concealment. BC addict Dennis Williams, 29, died in 1980 while being thus searched by RCMP officers, one of whom admitted at the coroner's hearing that he squeezed his throat "as hard as I could." After being told by the coroner that "Draconian measures" on the part of the police in dealing with drug users are "obviously a must," the coroner's jury returned a verdict of accidental death.

Evidence will be excluded from a trial only when it has been established that it was seized in direct violation of the suspect's rights under the Canadian Charter of Rights and Freedoms. The courts have held that if a police officer had reasonable grounds to believe that an addict had drugs in his mouth, then the search does not violate the suspect's guaranteed right to be free from unreasonable search and seizure.

Even if the addict can establish that evidence was seized in violation of his constitutional rights, it is not automatically excluded. The accused must prove that the admission of the evidence would bring the administration of criminal justice into disrepute. Canadian courts have taken a very narrow view of what brings the administration of criminal justice into disrepute.

Moreover, an officer who has a writ of assistance may enter and search, day or night, any home or residence in which he reasonably believes there is an illicit drug. Such conduct would constitute a random search in the US because the writ of assistance is a general search warrant which was violently opposed in the American revolution and is now prohibited by the 4th Amendment to the US Constitution. In Canada, however, the writ is still part of Canadian drug law. Once in a residence, under a writ, the doughty RCMP then have authority, as one Canadian legal scholar told me in despair, "to randomly strip search everyone there, including, if they happen upon them, nine nuns."

The Canadians, then, seem to have the worst of three worlds. Their police have US zeal, in excess, regarding narcotic use. They function within British-style laws which provide wide leeway for enforcement officials and which presume that the greatest restraint will be found in the self-restraint of officials. And the Canadian people have enormous respect for authority, even timid deference to it.

These, as I say, are first impressions, which I reach with sadness. Are they wrong?

** Arnold S. Trebach, PhD, is the Director of the Institute on Drugs, Crime and Justice, The American University, Washington, DC, author of The Heroin Solution, and an occasional columnist for* **The Journal.**

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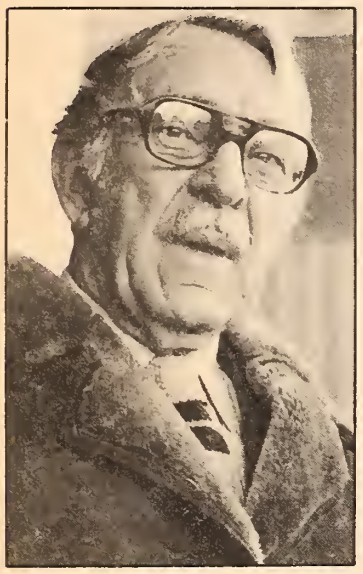
NEWS

Governments underspend on alcoholism: Strachan

MONTREAL — Governments in Canada are not spending nearly enough to counteract "the costs in human misery and suffering" from alcohol abuse, says a long-time voice in Canada's alcoholism field.

That means "all too many Canadians seek and achieve costly care in the United States," says J. George Strachan, LLD.



Strachan: Squeezing revenues

Dr Strachan says federal and provincial government inaction remains an enigma to workers in the addictions field because the "astronomical" costs to society and the economy are ignored.

"Yet, they (the governments) continue to squeeze the revenues derived from the manufacture, sale, distribution, and social use of beverage alcohol to support the treatment and prevention of other ills, but not the ills or issues that this lucrative source of revenue creates," he said.

Dr Strachan organized The Alcoholism Foundation of Alberta, forerunner of the Alberta Alcoholism and Drug Abuse Commission (AADAC). He was speaking here to the conference on Alcoholism and Other Drug Dependencies co-hosted by the Association des Intervenants en Toxicomanie du Quebec and la Maison Jean Lapointe.

"Alcoholism seriously deters complete and lasting recovery from any other ill, while causing unnecessary fatalities because the number one illness — alcohol dependency — remains ignored," Dr Strachan said.

One solution, he told the delegates, is "to improve the attitudes of those people on the outside who represent public opinion and who thus control the output and degree of services and support decreed by governments and the private sector."

It's also important to re-examine how information campaigns on alcohol-related problems are carried out, he says.

"It's all very good to provide meaningful public information to attract those who will need help to seek and accept it. But when we do, the care facilities and resources essential to providing that care must be in place."

A coordinated effort among a variety of resources and health officials is also necessary to get the message across, Dr Strachan says.

"To orient one nurse or doctor or teacher to (his or her) community role is not to reach all members of those professions — old, current, or new. Until all teaching and learning mainstreams share this responsibility, the local programs must assume a continuing obligation to maintain these functions."

Dr Strachan says these measures are important when one considers how the problem has grown in the past 25 years. In the 1950s, it was estimated that one in every 16 people who drank was alcoholic; now it's one in nine. There are also more women alcoholics now than 25 years ago, he adds.

Nevertheless, the alcoholic can be treated successfully, he says, "if the alcoholism is accepted, treated, and respected as the number one illness in the patient's life. All other disorders, complaints, maladies, and issues are secondary."

In recognition of his lifetime work on alcoholism, Dr Strachan was recently presented with the AADAC's first Distinguished Service Award.

He was also honored by having AADAC's library renamed after him.

Security is stepped up

Flight crews trained to spot smugglers

WASHINGTON — United States airline flight crews will be given special training in how to recognize possible drug smugglers as part of a anti-drug-smuggling program drawn up by the industry's Air Transport Association.

Other actions by the airlines will include more intense scrutiny of inbound cargo from abroad; concentration on certain flights from cities abroad known for trafficking; and tighter security on aircraft including more limits on access.

US Customs Commissioner William von Raab said the efforts by the airlines will not only help customs and Drug Enforcement Administration officials, but will also send a message to management and employees that they are involved in fighting drug trafficking.

Medical students intrigued by course in addictions

ATHENS — Swedish medical students are getting hooked on a new alcohol and drug dependence course at the Karolinska Institute in Huddinge, Sweden.

The two-week course, which began at the Institute last fall, is divided into a week of lectures and a week of clinical training in the alcohol and drug dependence unit.

A survey of students taking the course showed they significantly increased their interest in drug and alcohol problems and were more inclined to work within the field than they had been before studying the subject.

These findings were presented by Ulf Rydberg at the 14th International Institute on the Prevention and Treatment of Drug Dependence here.

Suspensions, no pay face baseball pros who break drug code

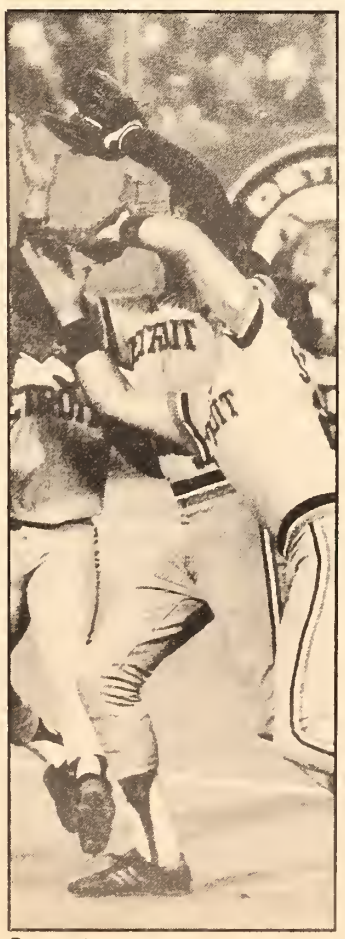
NEW YORK — Suspension of play and pay for at least one year, and possibly for life, and random screening at any time face major league baseball players involved in drug use and distribution.

The tough new code agreed to by owners and players and handed down by Commissioner Bowie Kuhn is part of a new drug abuse program for ball players (**The Journal**, April).

Rules are firm. There will be minimum suspension without pay for one year and a maximum penalty of permanent ineligibility for: players convicted of (or pleading guilty to) a crime related to distribution of controlled substances; players who facilitate the use by others of a controlled substance; or players convicted of (or pleading guilty to) a crime related to possession or use of a controlled substance.

In addition, any player found in possession of any controlled substance on the playing field, or the premises of the stadium, will automatically be suspended for a year without pay.

When a player is on suspension, he will be subject to mandatory and unannounced screening to ensure he is no longer involved with drugs.



Drug rules are firm

NEWS

Tobacco use a new focus for ICAA

By Lachlan MacQuarrie

HONG KONG — Support for drug and alcohol training programs in developing countries, and concern with tobacco dependence, will be major new interests for the International Council on Alcohol and Addictions (ICAA), says its president, H. David Archibald.

Mr Archibald said here the focus on training programs is aimed at "increasing substantially the number of people available to help contain the problems of alcohol and drug dependence and to develop programs for prevention."

He said a successful ICAA-supported training program is already underway in Nigeria; this is to be followed by similar programs in countries of Africa and Asia, including Zambia, Kenya, and Malaysia.

The ICAA has also officially extended its terms of reference to include the dependence aspects of smoking and its impact on health.

"Thus, this major area of substance abuse can now be included for the first time in our ICAA program," Mr Archibald said.

He urged 360 delegates from 30 countries at the 2nd Pan Pacific Conference on Drugs and Alcohol, to collaborate internationally and to redouble efforts to be mutually supportive. He added that ICAA is ready to assist within the limits of financial and human resources.

"In these days of instant worldwide communication, we need to spread information about good programs as rapidly as possible," he said. "The need for collaboration is absolutely critical.

"We have discovered that countries are no longer isolated one from another, and that the value systems of one country will inevitably spread and influence other countries. Lifestyles and customs will spread almost as rapidly as jet liners can drop us down in various parts of the world.

"Sadly, the spread of substance abuse is now also rapid. Drugs, alcohol, and tobacco are contributing to enormous damage the world over," Mr Archibald added. "Unless we learn to collaborate with each other, the future is bleak."

NZ doctors pare barbiturate scripts

AUCKLAND — Government intervention has cut the use of barbiturates and minor tranquillizers in New Zealand.

The average number of barbiturates sold to retail pharmacies each month dropped to 100,000 last year from more than 500,000 in 1978. The average number of minor tranquillizer tablets sold to pharmacies each month fell to 3.5 million last year from almost 5.5 million in 1978.

In 1979, the health department introduced restrictions on payment for minor tranquillizers. Payment was authorized for a maximum quantity sufficient for 30 days of treatment on any one prescription form.

In 1980, the prescribing of barbiturates was restricted to controlled-drug prescription forms, with only one month's dosage to be dispensed at a time.

The department says the success of the restrictions can be attributed to an increased awareness among doctors of the appropriate indications for prescribing the drugs.

Researchers are ignoring 'pathological gambling'

By Lillian Wylie

LOS ANGELES — Pathological gambling is a common and devastating disorder, estimated to affect between one million and three million people in the United States.

"Science has recognized pathological gambling as a diagnostic entity, but it is neglected in terms of research," says Robert D. Linden of Harvard Medical School, Mailman Research Center, and McLean Hospital, Belmont, Massachusetts.

"Pathological gambling has been viewed variously as an indication of personality disorder, a disorder related to substance abuse, or, more recently, as a variant of affective disorder," Dr Linden reported here to the American Psychiatric Association annual meeting.

Family studies suggest a link between pathological gambling and affective disorders. To date, only one study has tested these hypotheses. To further investigate this possible relationship, Dr Linden — assisted by Drs Jeffrey M. Jones and Harrison G. Pope — performed a pilot study of the phenomenology and family history of 15 pathological gamblers.

The 15 subjects were recruited from Gamblers Anonymous (GA), all volunteered, and all met established psychiatric criteria (DSM-III) for pathological gamblers.

All subjects were male, and aged 34 to 70 years. Six had received outpatient treatment for psychiatric illness. Thirteen were married, and two divorced.

The time since they had last gambled was from one week to 16 years; years in GA ranged from 1.5 to 23 years. At the time they stopped gambling, indebtedness was between $1,700 and $1,500,000; nine subjects had debts of more than $39,000.

All subjects received three separate interviews, including reviews of family history and psychiatric illness.

Interpretation of the results is limited by the small sample size and uncertainty about whether the sample was representative, Dr Linden said. However, it was noted that the phenomenological data favor a relationship between pathological gambling and major affective disorder.

Some 87% of subjects reported at least one episode of major depression, and 53% displayed either recurrent episodes of major depression, or bipolar disorder. Other disorders which may be in the affective spectrum, such as panic disorder and obsessive/compulsive disorder, were also present in the sample.

Dr Linden said further studies, particularly of active gamblers, are needed to characterize the nature of pathological gambling and assess the contribution of major affective illness to this disorder.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000 ext 7384.

Sons and Daughters: Drugs and Booze

Number: 612.
Subject Heading: Alcohol and youth, drugs and youth.
Details: 28 min, color.
Synopsis: One of the most difficult things parents might ever have to face is drug use by their children. Using examples, children's drug use is explored within family contexts. What parents might do if they suspect drug use and how to confront their children are illustrated.
General evaluation: Fair (3.4). This film was judged to be a good discussion starter about how to deal with adolescent drug use within the context of the family. General broadcast was recommended.
Recommended use: With a resource person this film could benefit parents and health professionals.

Children of Denial

Number: 613.
Subject heading: Alcoholism and the family.
Details: 28 min, color, 16 mm.
Synopsis: Claudia Black works with children of alcoholics. She lectures about the problems these children have, including difficulty in expressing themselves verbally, trusting people, and acknowledging their emotions. Ms Black tells her audience that these children must be taught about alcoholism in order to overcome these problems.
General evaluation: Poor (2.4). While the information presented was good, the Assessment Group found the lecture method of presentation too long and boring.
Recommended use: With a resource person this film could be used by parents and health professionals.

Smoking, Drinking and Drugs

Number: 614.
Subject heading: Drugs and youth.
Details: 14 min, color.
Synopsis: A boy puppet sees an old man puppet smoking a cigarette. The old man says that he started smoking before there was enough information about the dangers of smoking. The young boy decides to find out about cigarettes and other drugs (eg, alcohol) before he gets into a similar situation. He and a friend visit a doctor who tells them about drugs and their harmful effects.
General evaluation: Fair to good (3.9). This film was judged a good teaching aid that could lead to attitudes opposed to drug use. General broadcast was recommended.
Recommended use: Could benefit children aged eight to 12 years.

Remember When?

Number: 615.
Subject heading: Treatment/rehabilitation.
Details: 15 min, color, 16 mm.
Synopsis: A man who is in treatment is still finding it difficult to remain abstinent. When he has a bad day, his first thought is about how a drink, in the past, made him feel so much better. However, he is cautioned to remember where his drinking led him — for example, self-disgust, sickness, and problems with his family. He decides that there are better ways to work off anger and frustration than drinking.
General evaluation: Fair to good. (3.7). This film was judged to be a good teaching aid that could lead to attitudes opposed to drug use.
Recommended use: This film would be of benefit to patients in treatment for alcohol problems.

NEWS AND DEPARTMENT

There's nothing to discuss on cigs, says cancer chief

By Jean McCann

TORONTO — At the annual meeting of the American Association for Cancer Research (AACR), the new president questioned why that organization had to go on record as being opposed to smoking.

When the organization passed a resolution here against smoking, "I was very surprised," Isaiah J. Fidler told **The Journal**. "I took it for granted we would necessarily be opposed to smoking."

He said the problem is that a new media blitz is asking: 'Are you really sure cigarettes cause cancer? Let's discuss it.'

"They sound like the comedienne Joan Rivers," said Dr Fidler. "What is there to discuss?"

Dr Fidler, head of the department of cell biology, MD Anderson Hospital and Tumor Institute, Houston, Texas, made the comments in an interview in which he said that preventing cancer was one of the main thrusts of cancer research today.

"I am not very hopeful about prevention, though, when our society had to pass a resolution affirming our stand that smoking is most injurious to one's health and that smoking of tobacco products has been identified as the leading cause of lung cancer, making it a preventable disease.

"What distresses me the most is that despite our knowledge, we really don't see an appreciable decrease in the amount of smoking. The very fact that our society had to take out a position paper (saying) cigarette smoking is injurious is very telling."

At the AACR meeting, believed to be the largest gathering of cancer researchers anywhere, there were only a few papers directly involved in smoking research.

Fidler: took it for granted

One study, from the Cross Cancer Institute in Edmonton, Alberta, suggests there may be a link between cancer of the ovary and cigarette smoking. In a study of 100 patients with this disease, who were compared to women who did not have cancer of the ovary, Dr M. Koch and colleagues found lifetime consumption of cigarettes was about twice as high for the patients as for the controls.

The researchers said this should be studied further and, if the relationship is confirmed, researchers should ask why.

Another report, from I.M. Sasson and colleagues at the Institute for Disease Prevention, American Health Foundation, Valhalla, NY, suggests diet may play a role in determining who gets bladder cancer. They confirmed that while cigarette smokers do have possibly pre-cancerous, mutagenic substances in their urine, people who ate an all-vegetable diet had, in some cases, even more mutagens, or mutation-causing substances.

"These results imply that dietary factors can play a dominant role in mutagenicity," the researchers concluded. For that reason, they said, studies should take into consideration not only if people smoke, and how much, but what they eat.

New Books

by RON HALL

Cannabis and Health Hazards

. . . edited by Kevin O'Brien Fehr and Harold Kalant

This volume contains the papers presented at an Addiction Research Foundation/World Health Organization Scientific Meeting on Adverse Health and Behavioral Consequences of Cannabis Use. It offers a perspective gained from observation in Third World countries as well as in Europe and North America. It contains a detailed consideration of the relation between cannabis doses used in experimental animals and those consumed voluntarily by humans for non-medical purposes. Chapters are devoted to clinical toxicology of cannabis use; cannabis, marijuana, and cannabinoid toxicological manifestations in man and animals; effects of cannabis smoke on cellular biochemistry of *in vitro* test systems; immunological effects of cannabis; effects of cannabis on reproduction, endocrine functions, development, and chromosomes; acute psychological effects on human brain function and behavior; tolerance and dependence; and epidemiological aspects.

(Addiction Research Foundation, Marketing Services, Dept JR, 33 Russell St, Toronto, Ontario M5S 2S1, 1983. 843 p. $65. ISBN 0-88868-084-8)

The Little Black Pill Book

. . . by Lois B. Morris; Robert Garrett; Ursula Waldmeyer; and Lawrence D. Chilnick

The stated purpose of this book is to provide educational information to the public concerning the majority of psychoactive prescription drugs which are presently utilized by physicians. It is not intended to be complete or exhaustive, or in any respect substitute for personal medical care. Critical variables of pill abuse are discussed, such as, the physical characteristics of the individual taking the drug, psychological characteristics, including attitude, and the environment in which the drug is taken. The first section of the book deals with the physical and psychological aspects of drug abuse; identifying the problem; getting help; the doctor's responsibilities; legal aspects; and look-alike drugs. The second section is devoted to discussions of the most commonly prescribed psychoactive drugs in the United States, generic, brand and street names, with complete profiles of drugs and their effects. There are 16 pages of full color photographs of drugs.

(Bantam Books, 666 5th Ave, New York, NY 10103, 1983. 272 p. $3.95. ISBN 0-553-23786-1)

Other books

Identifying and Measuring Alcoholic Personality Characteristics — Cox, W. Miles (ed). Jossey-Bass Publishers, San Francisco, 1983. Identifying pre-alcoholic personality characteristics; alcoholics' perceptions of control; gender differences in alcoholic personality characteristics and life experiences; differential personality inventory types among alcoholics; index. 107 p. Jossey-Bass Publishers, PO Box 62000, San Francisco, CA 94162. $7.95. ISBN 87589-964-1.

Drug Trafficking: A North-South Perspective — McNicoll, Andre. North-South Institute, Ottawa, 1983. Historical perspective; producers and consumers; rural development; supply and demand. 94 p. North-South Institute, 185 Rideau, Ottawa, ON K1N 5X8. $6. ISBN 0-920494-39-0

Cocaine: The User's Guide to Self-Help Treatment — Meyers, H. Alan. National Addiction Research Foundation, Inc, San Francisco, 1983. Social evolution of cocaine use; progression of psycho/physiological stages; stages of intoxication; pyramid progression of cocaine use/abuse; alcohol and other drugs; self-treatment plan; suggested diet; exercise; leisure time activities; values; learning to relax. 43 p. National Addiction Research Foundation, Inc, 50 Liberty, San Francisco, CA 94110. $10.

This publication is indexed in
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Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Management for Supervisors in the Health Care Setting — Aug 13-14, Halifax, Nova Scotia, Aug 16-17, Toronto, Ontario. Information: Ingrid Norrish, Program Manager, Professional and Management Development, Humber College, Box 1900, Rexdale, ON M9W 5L7.

Canadian Society of Forensic Science 31st Annual Conference —Aug 18-24, Winnipeg, Manitoba. Information: Executive Secretary, Canadian Society of Forensic Science, 171 Nepean St, Ste 303, Ottawa, Ontario K2P 0B4.

Canadian Medical Association Annual Meeting — Aug 20-24, Edmonton, Alberta. Information: Canadian Medical Association, 1867 Alta Vista Dr, Ottawa, Ontario.

100th Canadian Convention of the Woman's Christian Temperance Union — Aug 20-Aug 24, Willowdale, Ontario. Information: A. H. Rawlins, Canadian Woman's Christian Temperance Union, 875 Sunset Blvd, Woodstock, ON N4S 4A5.

1984 Annual Convention of the American Psychological Association — Aug 24-28, Toronto, Ontario. Information: American Psychological Association, 1200 17th St, NW, Washington, DC 20036.

Health Policy Conference on Canada's National Health Care System — Aug 26-31, Banff, Alberta. Information: Dave Rochefort, Program Manager, Management Studies Programs, The Banff Centre School of Management, Box 1020, Banff, AB T0L 0C0.

Fundamental Concepts — Sept 17-21, Jan 7-11, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, (ARF) 8 May St, Toronto, ON M4W 2Y1.

University of Toronto Department of Psychiatry 10th Annual Research Day — Sept 21, Toronto, Ontario. Information: K. Drysdale, Secretary, Research Fund Committee, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Pharmacology and Drug Abuse Course — Sept 24-27, Feb 25-28, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Detox Training Programs (Nonmedical) — Sept 24-28, Oct 22-26, Nov 19-23, Toronto, Ontario. Information: Diane Hobbs, Coordinator of Detox and Rehabilitation Programs, ARF, 33 Russell St, Toronto, ON M5S 2S1.

AADAC Mini-School 84: Children of Alcoholics: Beyond The Lingering Legacy — Sept 30-Oct 2, Calgary, Alberta. Information: Alberta Alcoholism and Drug Abuse Commission, 3rd fl, 1177-11th Ave, SW, Calgary, AB T2R 0G5.

Introductory Addictions Management Course — Oct 10-12, Nov 21-23, Apr 10-12, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Workplace 84 "Making the Most of Human Potential" — An Employee Assistance Programming Conference — Oct 15-17, Grande Prairie, Alberta. Information: Iyas Abbas, Alberta Alcoholism and Drug Abuse Commission, Provincial Building, Rm 2204, 10320 99 St, Grande Prairie, AB T8V 6J4.

Basic Counselling Skills Course — Oct 15-19, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

5th Annual Meeting Canadian Group Psychotherapy Association — Oct 17-20, Ottawa, Ontario. Information: Edgardo Perez, MD, department of Psychiatry, Civic Parkdale Clinic, 3rd fl, Ottawa Civic Hospital, 737 Parkdale Ave, Ottawa, ON K1Y 4E9.

22nd Annual Scientific and Business Meeting — Oct 17-20, Toronto, Ontario. Information: Lyn Robinson, Chairman, 1984 Convention Committee, Ontario Chapter College of Family Physicians of Canada, 4000 Leslie St, Willowdale, ON M2K 2R9.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-10, 1985, Calgary, Alberta. Information: Jan Skirrow, Chairman, 34th ICAA Congress, AADAC, 6th fl, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

United States

New Jersey Summer School of Alcohol and Drug Abuse Studies — Aug 5-10, New Brunswick, New Jersey. Information: Summer School of Alcohol Studies, Rutgers University, New Brunswick, NJ 08903.

The International Doctors in Alcoholics Anonymous Annual Meeting — Aug 9-12, Minneapolis, Minnesota. Information: Lewis Reed, MD, Information Secretary, IDAA, 1950 Volney Rd, Youngstown, Ohio 44511.

North American Congress on Employee Assistance Programs — Aug 12-15, Dearborn, Michigan. Information: Diane Vella, Congress Coordinator, NAC/EAP, 2145 Crooks Rd, Ste 103, Troy, MI 48084.

7th Annual School for Alcohol and Drug Studies — Aug 12-17, Wilmington, North Carolina. Information: North Carolina School for Alcohol and Drug Studies, Office of Special Programs, UNC-Wilmington, 601 S College Rd, Wilmington, NC 28403-3297.

2nd Annual Institute in the Management of Substance Abuse Services: The Clinician to Manager Transition — Aug 14-16, Cambridge, Massachusetts. Information: Barry Sugarman, PhD, Lesley College Graduate School, 29 Everett St, Cambridge, MA 02238.

Alcohol and Drug Problems Association 35th Annual Conference — Aug 19-23, Washington, DC. Information: Eric Scharf, ADPA, 1101 15th St NW, #204, Washington, DC 20005

16th Annual Nevada Substance Abuse School — Aug 20-24, Las Vegas, Nevada. Information: Angela L. Alaimo, Bureau of Alcohol and Drug Abuse, 505 E King St, 5th fl, Carson City, NV 89710.

8th Summer Institute for Drug Dependence — Aug 26-31, Colorado Springs, Colorado. Information: The Institute for Integral Development, PO Box 2172, Colorado Springs, CO 80901.

Relational Issues of Addiction: Violence, Sexuality, and Intimacy —Sept 17-19, San Diego, California. Information: Naomi Feldman, Conference Coordinator, 3770 Tansy, San Diego, CA 92121.

3rd National Conference National Federation of Parents for Drug-Free Youth — Sept 27-29, Washington, DC. Information: National Federation of Parents for Drug-Free Youth, 1820 Franwall Ave, Ste 16, Silver Spring, MD 20902.

4th Annual Workshop on Marketing Mental Health Services and Employee Assistance Programs — Sept 30-Oct 2, Breckenridge, Colorado. Information: Laurie Loeb, Colorado West Regional Mental Health Center, PO Box 40, Glenwood Springs, CO 81602.

Current Concepts of Addictions Nursing — Oct 4, Chicago, Illinois, Nov 1, Orlando, Florida. Information: NNSA-Seminars, 2506 Gross Point Rd, Evanston, IL 60201.

Alcohol and Drug Problems Association (ADPA) Northwestern Regional Conference — Oct 7-9, Seattle, Washington. Information: Eric Scharf, Alcohol and Drug Problems Association, 1101 15th St, NW, #204, Washington, DC 20005.

18th Annual Association for the Advancement of Behavior Therapy Convention —Nov 1-4, Philadelphia, Pennsylvania. Information: John E. Martin, PhD, Program Chairperson, AABT/84, Psychology (116B), VA Medical Center, Jackson, Mississippi 39216.

Current Clinical Psychopharmacology — Nov 2, New Hyde Park, New York. Information: Ann J. Boehme, Continuing Education Coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042.

4th Annual Fall Conference on Alcoholism — Nov 7-9, Williamsburg, Virginia. Information: Craig Nuckles, director, Riverside Hospital Alcoholism Treatment Program, J. Clyde Morris Blvd, Newport News, VA.

AMERSA (Association for Medical Education and Research in Substance Abuse) 8th Annual Conference — Nov 8-9, Washington, DC. Information: Conference Coordinator, c/o David Lewis, MD, Brown University, Program in Medicine, Box G, Providence, RI 02912.

2nd National Conference on Alcohol and Drug Abuse Programming for Colleges and Universities — Nov 11-14, Boston, Massachusetts. Information: Eric Scharf, Alcohol and Drug Problems Association, 1101 15th St, NW, #204, Washington, DC 20005.

9th Southeastern Conference on Alcohol and Drug Abuse — Nov 28-Dec 2, Atlanta, Georgia. Information: Barbara Turner, Charter Medical Corporation, Addictive Disease Division, 5780 Peachtree Dunwoody Rd, NE, Ste 170, Atlanta, GA 30342.

Abroad

International Conference on Alcoholism and Other Drug Abuse — Aug 12-15, Lima, Peru. Information: Mary Vasquez, PhD, VMC, Employee Assistance Programs, 38760 Northwoods Dr, Wadsworth, Illinois 60083.

3rd International Conference on Treatment of Addictive Behaviors — Aug 12-16, North Berwick (Edinburgh), Scotland. Information: William R. Miller, PhD, department of Psychology, University of New Mexico, Albuquerque, New Mexico 87131.

Alcohol, Drugs and Criminality — Aug 13-18, Quito, Ecuador. Information: Dr Hernando Rosero Cueva, Apartado 3663, Quito, Ecuador.

5th World Congress on Prevention — Aug 26-30, Rio de Janeiro, Brazil. Information: Ernest H. J. Steed, Executive Director, International Commission for the Prevention of Alcoholism and Drug Dependency, 6830 Laurel St, NW, Washington DC 20012.

8th World Conference of Therapeutic Communities — Sept 2-7, Rome, Italy. Information: Charles J. Devlin, Executive Director, Daytop Village Inc, 54 W 40th St, New York, NY 10018.

Seminar on Addiction — Sept 6-14, Athens, Greece. Information: Darcy Edwards, Millglen Medical Corp, PO Box 888673, Atlanta, Georgia 30356-0673.

International Congress on Alcohol Dependence, The Family and The Community — Sept 16-22, Jerusalem, Israel. Information: International Congress on Alcohol Dependence, the Family and the Community, Kenness International Inc, 1 Park Ave, New York, NY 10017.

International Workshop on Punishment and/or Treatment for Driving Under the Influence of Alcohol and Other Drugs. Current Concepts and Prospectives. Pros and Cons. — Oct 19-20, Stockholm, Sweden. Information: ICADTS, Box 5815, S-102 48 Stockholm, Sweden.

"Addiction: A Hundred Years On" Centennial Symposium — Oct 25-26, London, England. Information: The Royal Society, 6 Carlton House Terrace, London SWI, England.

2nd Inter-American Symposium on Health Education — Nov 4-9, 1984, Acapulco, Mexico. Information: Symposium Steering Committee, c/o NARO, PO Box 2305, Station D, Ottawa, Ontario, K1P 5K0.

Prophylactics of Drug Abuse — Dec 10-12, Warsaw, Poland. Information: Secretariat of the Symposium, Society for Prevention of Drug Abuse, Aleje Ujazdowskie 22, 00-478 Warsaw, Poland.

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The drug-trade fallout in Shangri-La

Katmandu — reeling in the wake of the 60s

Calculated non-action passes for policy in Nepal; the government insists local drug abuse is minimal, and that Nepali involvement in the global traffic is even less. International drug control bodies are convinced this does not reflect reality, but they have so far failed to persuade the government even to endorse a systematic survey offered under United Nations aegis in December 1982, writes correspondent ***Gamini Seneviratne*** *from Nepal.*

Katmandu market square: the flower people have gone Photos by Seneviratne

Twenty years ago, the first waves of Western youth came to Katmandu — in search of Shangri-La and inexpensive hashish. They swarmed about the cobwebbed streets, among the intricately carved wooden architecture of the tumbledown old city, in a state of collective stupefaction. They called the city centre Freak Street; the name survives in tourist maps, having elbowed out a twisting alley named Jhochlen Street.

This seems to be the scene on which Nepal still opts to focus, officially. But privately, even senior officials and other influential citizens are fiercely critical, particularly when their anonymity is assured. They realize that the ethos of Freak Street has changed dramatically.

The flower people have gone. Local hashish is scorned. The drug of choice is heroin. The supply of other drugs and hashish from the Middle East is plentiful. Import and export flourish. Nepali addicts in Katmandu outnumber resident foreign addicts by at least 100 to one. The sub-culture spawned in the 1960s is spreading across society and the country. Today, not only Freak Street is in a fix.

In the absence of any study — the favorite escape clause of officialdom — it is difficult, though not impossible, to work out addiction numbers and trends. There are many "businessmen" in Katmandu who confess to being "reformed" pushers; and they appear to agree there are now about 12,000 Nepali heroin addicts in the capital city (estimated pop:250,000) of this landlocked Himalayan kingdom of just over 15 million people.

Other estimates are lower. A Nepali law graduate recently completed a painstaking survey of students at 10 university campuses across the country, for his thesis on the legal aspects of drug use. His paper is not recognized for any official purpose, but he did estimate that 10% of male students took drugs regularly and that 3.5% were on heroin.

Among the tiny number of people who work regularly on drug abuse prevention and control are Dhauba Man Shrestha, a general psychiatrist at the state-run Lagankhel Mental Hospital, and United States-born Nepali citizen Father Thomas Gafney, a Jesuit priest who runs a number of addiction services including his own rehabilitation centre for drug addicts. They agree, separately, based on their many contacts and probing conversations with clients, that there are from 5,000 to 8,000 Nepali addicts in the capital. The figure contrasts, they both say, with fewer than 50, eight years ago. The Nepali addicts are no longer predominantly from among the displaced poor. One businessman whose brother is an addict says: "A few years ago, in the Freak Street area, morning and evening, you saw young men lying about, totally stoned. That is not so common now. Instead, you see youths drive up on motorbikes, give signals, make their purchases, and drive off."

Trinket seller: scorning drugs, remembering 'dead' friends

THE BACK PAGE

Father Gafney says this corresponds with a change in his clientele. "They are no longer mainly the most deprived — orphans from villages typically — with no education and no hope in the big city, who took drugs to get on the 'inside' so they could traffic. Now, many are the sons of better-off families, of senior government officials, who by and large can pay for treatment."

Says Dr Shrestha: "Drug abuse and drug dealing, in fact the first exposure to hard drugs, were introduced by the youth 'revolution' of the 1960s. The first Nepali pushers were recruited by street boys. But today's addicts include those in high society — mostly young and mostly male, though I am sure there are some girls too."

The "society" addicts are nearly all *terra incognita*; they are never arrested, and they are either sent abroad for treatment, mostly to Bangkok, Calcutta, and Madras, or go to private doctors in Katmandu. The fact tends to give more credence to pushers' estimates of addicts than to those of practitioners like Dr Shrestha and Father Gafney.

Pushers and practitioners alike now put the figure for resident foreign addicts at fewer than 50, or one foreigner to at least 100 Nepalis, a ratio particularly relevant in the face of government insistence that most addicts are foreigners.

Ironically, the government's revised residence regulations, though not aimed directly at the drug scene, have nevertheless drastically cut the number of non-Nepali addicts living here.

A three-month renewal of a resident's visa, for example, costs 1,800 Nepal Rupees (US $128.57) and a lot of hassle. Foreign addicts maintain bank and savings accounts, and very low profiles. Most have visa "fronts" such as designing jewellery and other similar items for local craftsmen. Some may be "exporting" more than such handicrafts, says Father Gafney, but others genuinely do want to continue living in Nepal.

Itinerant foreigners still abound. Most are young and most of them use drugs, at least in passing. And they have no difficulty finding whatever they want. Trade is but one level below the counter, and supplies appear to be plentiful. The law, when it is applied, is only to annoy, to indicate police presence.

Morphine, the booty of burglaries, may be bought in medical shops or in the street. Those who desire codeine buy the local cough syrup which has "codeine" in its tradename. Ask for the hypnotic, phenobarbitone, 500 or 1,000 tablets, and the only question asked is, "what strength?" Though some chemists diligently demand prescriptions, almost all synthetic drugs can be bought legally and openly.

The exception is Demorol (pethidine or meperidine), said to have the same effect as morphine and preferred by dabblers in the mistaken belief that it is less addictive. The drug is used in surgery and considered by many to be the drug of choice of medical personnel in Nepal. On the streets, the most easily available is still the local hashish; cannabis grows by the roadside, even in Katmandu. But it is now scorned in comparison with quality hashish coming in from the Middle East. In fact, almost all drugs seem to come from abroad.

Top of the list is heroin.

"If you want 20 to 25 kilograms of top quality, Grade 4, I can get it for you within one hour," says Father Gafney challengingly. "More will take a little longer." By common account, the price for pushers and other bulk-buyers is NR 250,000 (US $17,857) a kg. Retail price is NR 400 ($28.57) a gram, down from two years ago, because of bumper opium harvests in the Golden Crescent and new processing laboratories in Pakistan. A daily Karachi-Katmandu airline link was also begun last year.

A very recent entrant is a crudely processed opium, popularly known as "brown sugar," coming in from Benares in India. Difficult to dilute, it is normally heated in tinfoil and the smoke inhaled through a tube.

Raw opium is informally reported to be coming in overland from China. There is no word or indication of processing in Nepal, nor is there an apparent need, given the ease of supply.

One of the poorest of poor countries, landlocked by China, Sikkim, and India, Nepal is perilously close to the Golden Triangle and the Golden Crescent. Katmandu now has direct airlinks with Bangkok, Benares, Calcutta, Colombo, Dacca, Hong Kong, Karachi, New Delhi, and Rangoon. From a drug controller's viewpoint, a more telling 10-city combination is difficult to imagine.

The International Narcotics Control Board (INCB) in 1983, and for the first time, referred in its report to Nepal's vulnerability by air: "Insufficiently strict airport controls at Khatmandu are exploited by traffickers." Yet the Nepal government steadfastly maintains the country is unaffected.

In recent months, King Birendra of Nepal has said to foreign journalists who managed to see him: — "drug traffic from or in Nepal is not that great . . . the problem starts with processing and that is a Western technique . . . the majority of Nepalese are not involved . . . the challenge to control is welcome . . . Nepal cannot do it alone . . . we have signed all the international laws and try to cooperate in every way."

This has all the makings of a committee-prepared answer and is inaccurate in at least one particular: Nepal is not party to any international drug convention. It has also spurned the advances of international bodies to conduct a study of the drug situation. Although one "training" workshop was held two years ago under the United Nations, it was open only to very senior officials who essentially were being asked to develop a strategy for responding to requests for information from UN drug agencies.

Said the INCB's 1983 report (not for the first time): "A wide range of drugs, including psychotropic substances, are readily available . . . and drug abuse, particularly of heroin, has taken its toll on the local population. Treatment facilities appear to be inadequate."

The only national seminar, on treatment and rehabilitation of drug abuse and addiction, sponsored by the Nepal Medical Association and the Colombo Plan Bureau, was held in Katmandu in September 1981. Its long list of recommendations has been ignored. The only development is Dr Shrestha's addiction unit in the mental hospital — which has no beds, is hopelessly understaffed, and can, at best, offer only some detoxification and some advice.

Worried Nepalis keep asking the same questions: What has the government done? Why do they refuse to see? If they don't know, why do they object to discussion?

There are three legislative enactments in Nepal against intoxicating substances and narcotic drugs. None is enforced.

Manitoba tunes kids in to health

p2

UN agriculture, health agencies clash on Third World Tobacco

The Back Page

Caffeine: history, habits, and health

p5-6

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The Journal

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Systematic, random spot checks work best

Current drunk-driving controls 'Neanderthal'

By Betty Lou Lee

HAMILTON — Politicians are the most backward part of society in taking a public health approach to drinking and driving, says a University of Western Ontario sociologist.

"They are absolutely Neanderthal in their public health approach," Paul Whitehead, PhD, told the 25th annual Institute on Addiction Studies, held at McMaster University here by Alcohol and Drug Concerns, Inc.

While opinion polls show the population favors more driver spot checks and raising of the drinking age — measures that can be effective — "legislators lag behind," he said. They favor steps like education programs and stiffer penalties for impaired driving, which don't work.

Dr Whitehead said forcing convicted impaired drivers to attend education programs has no effect on their recidivism. Nor do enforced treatment programs for those with multiple driving-while-intoxicated (DWI) convictions. The longer a licence is suspended, the longer the time until the second conviction, but when the data are controlled for the time factor, there is no difference in recidivism, he said.

Programs at Christmas and New Year's, when "all the community forces are mustered at one time" and the perceived risk of getting caught is high, do reduce impaired driving, said Dr Whitehead, who is the author of six books and more than 60 articles on alcoholism and drug abuse. His particular interests are prevention, public policy, and evaluation.

"The best way we know to reduce drinking and driving is random spotchecks on a systematic basis . . . with an increased level of enforcement at certain times of the day and week."

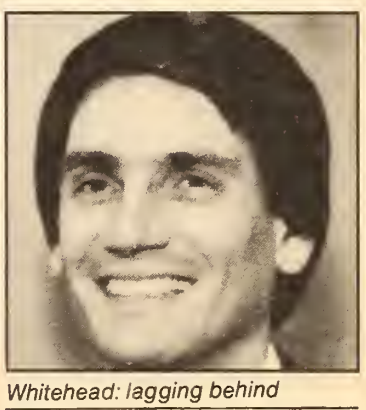
He termed 12- or 24-hour licence suspensions "a major step backwards." While the original idea was to use them when there was doubt the driver was above the legal limit, or it was difficult to take him for a breath test, in practice they are used on drivers who are "well above" the limit, he said.

The result is that DWI arrests go down, and the driver escapes a fine or conviction.

In Alberta, for example, DWI arrests dropped to 7,000 from 17,000 within a short period of the introduction of the temporary suspensions, he said. Yet Ontario adopted the same program more than six years after the Alberta evidence was clear.

Ontario is "not getting closer" to raising the drinking age from 19 years, even though "the evidence is clear" such a move would lower rates of fatal, personal injury, and property damage accidents among youth, Dr Whitehead said.

"If the age went from 19 to 20, it would affect the 16, 17, and 18 year olds who are the classmates of drinkers. If you want to reduce damage to the young, you raise the age to get legal drinkers out of the secondary schools."



Whitehead: lagging behind

Addicts trying new tricks to get Rx drugs

By Maureen Brosnahan

WINNIPEG — Drug store break-ins in Manitoba declined in the first six months of this year, reflecting a trend that is occurring across Canada, officials say.

But as break-ins and armed robberies drop off, drug abusers are turning to other illegal ways, such as forgeries or double-doctoring, to obtain prescription drugs, says Jacques LeCavalier, director of Canada's federal Bureau of Dangerous Drugs in Ottawa.

LeCavalier

Double-doctoring occurs when a person visits several physicians to obtain prescription drugs.

Between January and June of this year, 61 drug stores, hospitals, and medical clinics were broken into in Manitoba. This compares to 74 in the previous six-month period.

As well, there were only seven attempted break and enters here compared to 14 in the previous period, said Constable John Van Mulligen of the RCMP's (Royal Canadian Mounted Police) drug intelligence unit in Winnipeg.

Mr LeCavalier told **The Journal**, drug store break-ins across Canada have been dropping in the past few years with tighter security in pharmacies. And, with crackdowns by police on the illegal drug scene and dwindling supplies of illegal drugs in some regions, more abusers are finding ways to obtain prescription drugs to fill their needs.

"Indeed, in the last five years there has been a lot of pressure on the illegal market for drugs," he said.

Mr LeCavalier said in one recent case, five people were arrested and four convicted after they consulted 300 doctors for prescriptions. They obtained 40,000 Dilaudid (hydromorphone) tablets from 1,100 pharmacies.

The stolen Dilaudid was worth between $2 million and $3 million on the illegal market.

In Manitoba, the most noticeable drop in break-ins was in rural areas where the number dropped from 18 to six in the past six months.

Const Van Mulligen said this is likely a result of increased security and awareness among rural pharmacists through the provincial Program against Drug Diversion (PADD).

Stewart Wilcox, registrar of the Manitoba Pharmaceutical Association, told **The Journal** the introduction of the PADD program in the Brandon and Portage la Prairie areas has probably contributed to the decline.

The program, which is expected to be in full-swing throughout all regions of Manitoba later this year, involves a phone alert system where pharmacists call each

(See — Police — page 2)

Police cracking down on drug scams

Abusers pose as CA patients

By Maureen Brosnahan

WINNIPEG — Police and other drug enforcement officials in Manitoba are trying to crack down on two new drug scams being used by drug abusers to obtain prescription drugs illegally.

The two scams, which have been operating in the past two months, have fooled more than 100 doctors in Winnipeg and surrounding areas, and RCMP (Royal Canadian Mounted Police), city police, pharmacists, and doctors have all been alerted.

In one scam, patients go to doctors claiming to be suffering from Crohn's disease or a type of colitis. They explain the symptoms in detail and receive medication for that condition. They then ask for and receive Dilaudid (hydromorphone) or Leritine (anileridine), both narcotics, to ease the pain of the condition.

James Morison, MD, registrar of the College of Physicians and Surgeons of Manitoba told **The Journal**, about 80 doctors have been taken in by this story. In some cases, he said prescriptions obtained in Winnipeg have been filled in pharmacies as far away as Thompson, about 800 kilometres north.

The second scam involves a person who calls a local doctor and identifies himself or herself as a doctor calling long distance from Alberta or Ontario. They say they have a cancer patient who is moving to Winnipeg and request the local doctor to handle the patient's follow-up care by providing certain medications.

In some cases, the local doctor receives a second call from a person claiming to be a nurse or representative from the cancer society who is checking on a patient. This is an attempt to legitimize the case

The "patient" or a friend then appears at the doctor's office to pick up the narcotic prescription.

Rick Brown, regional director in Manitoba of the Bureau of Dangerous Drugs told **The Journal**, the second scam is new and about 15 to 20 doctors have been conned so far.

"It's a good scam, and it's something the doctors are going to have to be knowledgeable of," said Constable John Van Mulligen of the RCMP drug intelligence unit here.

Jacques LeCavalier, director for Canada of the Bureau of Dangerous Drugs in Ottawa, said such scams are nothing new and variations often crop up across the country. "The first one is a classic. It's been in operation in Canada for about the past five years," he said. However, he said the cancer story, which is much more sophisticated, was new to him.

"There have been so many

(See — Pharmacists — page 2)

Morison

Van Mulligen

INSIDE

NEWS

Briefly. . .

Alcohol rationing

STOCKHOLM — A citizens' group here has begun a campaign for strict alcohol rationing in restaurants and state-run liquor stores to reduce heavy drinking and drinking-related crime and disease. Statistics show a 20% decline in per capita consumption since 1976, but the National Committee for Alcohol Rationing sees the real problem resting with the 10% of drinkers it says account for 55% of consumption. The group has 150,000 of what they hope will be one million signatures supportive in their plea to the government which is still unconvinced further restrictions are needed.

Gasoline sniffing

DARWIN, Australia — Gasoline sniffing by Aboriginals in this country's Northern Territory (NT) has become a major concern for workers at the NT Drug and Alcohol Bureau. A range of measures has been tried with little success — including removing sniffers from the community, adding a malodorous chemical to the petrol, and restricting supply. Now, workers are suggesting interventions may have focussed too much on the act and the offender and too little on why people sniff. They also say the ill-effects may be being over-rated and, while sniffing should not be encouraged, over-emphasizing health risk warnings may, ironically, add to the problem.

Vineyards plundered

BRUSSELS — For ripping up their vines, wine producers in Europe will be paid a bonus by the European Economic Community (EEC) to try to eliminate the 704 million gallon wine surplus here. They will also have their right to replant restricted. The EEC stopped short of imposing quotas on wine production, but says they might be necessary if farmers continue to take advantage of price guarantees. Between 330 and 374 million gallons of the surplus will be distilled into industrial alcohol by the EEC.

MOD: no drinks at all

WASHINGTON — The United States March of Dimes (MOD) has sharpened its warning against alcohol consumption during pregnancy. The charity's earlier position urged women to consult their doctors about how much to drink; now it advises no drinking during pregnancy. MOD also supports warning labels on alcoholic beverages.

An old 'remedy'

CHRISTCHURCH, NZ — Packets of "asthma cigareets" containing stramonium, belladonna, and small amounts of cannabis, have been unearthed here during a house renovation. The cigarettes, used widely until the 1950s, for "hay fever or deeply-seated troubles of the respiratory organs," were "exempted from the DD (Dangerous Drugs) Act." Instructions on one brand found recommend "one cigarette should be smoked and inhaled before bed times. . ."

'Futuristic planning' must begin now: Schankula

Drugs may saturate Canada in 2015

By Betty Lou Lee

HAMILTON — The corner convenience store of the year 2015 may offer as wide a variety of alcoholic beverages as it now does soft drinks and dairy products.

They'll be packaged as milk is now, in easily opened, insulated, biodegradable containers. Or, like the ice cream cone, their containers may be edible — and thirst stimulating. The rum and cola or vodka and orange juice will be premixed.

These are some of the possibilities explored by Henry J. Schankula, director, education resources division, Addiction Research Foundation of Ontario, in the keynote address opening the 25th annual Institute on Addiction Studies, held here by Alcohol and Drug Concerns, Inc.

Some other possibilities, he said, are:

• At the same time as lower alcohol-content products are vigorously promoted — especially among the young — many countries will mix high-potency alcohol products with weaker indigenous alcoholic drinks.

• While multi-national corporations will control most of the western world market with brand names as recognizable in Japan as in Germany, small enterprises will cater to the particular tastes of highly localized audiences.

But these developments won't be met with general public equanimity, Mr Schankula predicted.

• Society will become less tolerant of drunkenness and drinking for the sake of intoxication.

• An additive that would cause discomfort and illness after a certain amount of alcohol has been consumed will be developed as a way of preventing dependence or addiction.

"The general public, frustrated by its concerns about increasing incidence of health costs in relation to alcohol and other drug use, will debate the acceptance of this additive . . . as fluoride being added to the water supply was debated in previous decades."

• Particular issues, such as drinking and driving, will continue to give rise to periodic campaigns by short-lived interest groups, "as the forces that promote consumption and business exceed the concerns for health.

"This will permeate the whole system. The Canadian population will be near the saturation point in terms of consumption of various alcohol and drug products. . . . Minimal efforts will be undertaken to provide a dramatic impact in areas such as education, prevention, and regulatory measures. Governments will continue to make enormous revenue from the sale and distribution of these products, and the disease and illness consequences will be taken as part of the cost of doing business."

• The previous generations that were unconvinced the hazards of cannabis outweighed its pleasures will be making widespread use of it by 2015, and taxation of marijuana will be an important issue in public debates.

• The Canadian government will consider laws to prevent Canadians from travelling to traditional vacation spots with liberal drug policies.

• While alcohol will still play a major role, there will be general acceptance of a wide range of drugs. Some countries will advocate use of opium, rather than heroin or cocaine, as being less harmful. More powerful psychoactives and cocaine-type products will be popular with the young.

• Women will reach equality with men in drug use — and in some cases surpass them.

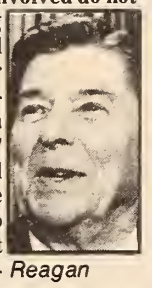
• Tobacco will be the one drug whose use diminishes, but it won't be eliminated, and governments won't try to prohibit it.

Pointing out it was conjecture whether any of these predictions materialize, Mr Schankula called for support for "the careful examination of the work that needs to be done to lessen "the harmful consequences" of widespread drug abuse.

This requires "futuristic planning," a greater, indeed much greater, fiscal commitment, and political resolve," he said.

US drink age hike law expected to go national

WASHINGTON — States in the United States which have not yet raised their minimum drinking age to 21 are expected to cave in rapidly following President Ronald Reagan's signature on legislation passed by Congress in June.



Reagan

If the 27 states involved do not raise the drinking age to 21 they will lose 5% of their highway construction funds in fiscal year 1987 and 10% in fiscal year 1988 (The Journal, July). No state can hold out against this financial pressure, which is allied with an almost evangelical anti-drinking and driving lobby.

While President Reagan, on political-philosophical grounds, originally opposed the idea of coercing the states with legislation, he said at the signing that his reservations were outweighed by the need to eliminate the morass of state laws which enabled young people to cross into a state with a lower drinking age than their own.

No federal legislation has been mooted — nor is it expected because it would be politically unpopular — which would effectively revoke the driving licences of all those convicted of drunk-driving charges.

Pharmacists suspicious of Dilaudid scripts

(from page 1)

scams," he said. "Every day there's a new one . . . nothing surprises me."

Mr LeCavalier said drug diversion is increasing across Canada as drug abusers attempt to seek new ways to obtain prescription drugs. "It's right across Canada, mainly in the cities."

He said in some cases, there may be a network in operation since drugs obtained illegally in some provinces are turning up on the illegal market in other areas of the country. For example, he said a quantity of Talwin (pentazocine) and Ritalin (methylphenidate) taken in Montreal was later found in British Columbia and Alberta.

"Some drugs are targetted in some areas and are shipped to others," he told **The Journal**.

Locally, Dr Morison has advised doctors to be wary of the new schemes. He said the cancer patient story is convincing because the woman who has been making many of the telephone calls has detailed knowledge of the symptoms of various kinds of cancers.

"Most of the doctors say she's very convincing but that she talks too much," he said.

Stewart Wilcox, registrar of the Manitoba Pharmaceutical Association, said that pharmacists became aware of the latest scams and alerted the other groups because many of the abusers were seeking Dilaudid.

Mr Wilcox said the drug is used almost exclusively for cancer patients but is popular with abusers. "It's a strong narcotic. It's the one closest to heroin," he said.

He said not all pharmacies carry it and pharmacists are naturally suspicious when presented with a prescription for it. As well, the drug, which sells legally for about $30 for 100 tablets, is being sold for $50 to $60 a tablet on the illegal market.

Meanwhile, police say they are frustrated because their attempts to track the scams are being foiled. In two recent cases, suspects who have come to pick up the drugs at a drug store have been apprehended by police.

But, in both cases, the suspects said they were collecting the drugs for an unnamed friend. "We haven't been able to charge anyone," said Sergeant Don Feener of Winnipeg police's fraud division.

Const Van Mulligen said the drug community is very close-knit and often information is exchanged on successful scams. When they discover one that works, it's repeated often, he said.

As well, when users stumble on a doctor who is willing to prescribe certain drugs without too many questions, he becomes prey for the others.

Police advising druggists to increase store security

(from page 1)

other when they spot a forgery or a case of double-doctoring.

As well, pharmacists, with help from the police, are given advice on how to increase security in their drug stores and deter criminals.

"I'm really proud of the way pharmacists have responded to this," Mr Wilcox said.

Const Van Mulligen said figures for forgeries and double-doctoring are difficult to gather since many are not caught for several months after thorough searches of drug store and prescription records. "I don't think a lot of doctors realize they are being double-doctored," he said.

While the type of drugs being stolen have not changed, fewer break-ins mean fewer drugs are being taken.

In all, pharmaceutical drugs worth $316,564 on the street were stolen in the past six months compared to $439,764 worth in the previous six months.

Most of the drugs stolen were narcotics and painkillers including Dilaudid, Talwin (pentazocine), Ritalin (methylphenidate), codeine, Demerol (pethidine/meperidine), Percodan (oxycodone), Lomotil (diphenoxylate), and Leritine (anileridine).

NEWS

Brewers, distillers get monopoly on sports

Public policy is encouraging youth drug use

By Betty Lou Lee

HAMILTON — Public policy in Canada does more to encourage than discourage alcohol and other drug problems among the young, says Don Smyth, alcohol and drug consultant to the Ottawa School Board.

There is a tendency to divide youth issues from adult ones, yet the best predictor of increases in alcohol use by the young is an increase in adult per capita consumption he told the annual Institute on Addictions Studies here.

Smyth

The one-third increase in alcohol consumption among Ontario students between 1970 and 1978 mirrored the increase for Canadian adults. In the past two years, both student and adult levels have stabilized, Mr Smyth said.

"Why is it that on each occasion the Ontario government has moved to restrict the legal drinking age — in 1978 to 19, and serious discussion in 1983 to 21 — it has coupled it with moves to liberalize restrictions on adult drinking — that is, to deliberately increase consumption?" he asked.

Provincial and major municipal governments "have worked in tandem to give brewers and distillers a virtual monopoly on sports.

"Indeed, the identification between sports and alcohol beverages is now so complete that during last spring's brouhaha over a refusal by a leading Canadian skier to participate in a tobacco sponsored meet (**The Journal**, April, March), there was absolutely no discussion of the fact that a hockey idol of Canadian youth was involved in lucrative liquor advertising while aiding a service club in its anti-drug campaign."

On the drinking-driving issue, the Ontario government has reinforced youth's sense of powerlessness, Mr Smyth said.

"If the basis of raising the drinking age is the over-involvement of youth in motor vehicle accidents, then, in a just society, action would be taken against all groups over-represented in accidents, powerless and powerful," he said.

Yet the government "put in moth balls" a 1983 report on truck safety that said trucks were over-represented in fatal accidents.

Mr Smyth said two measures the government could take to reduce drinking and driving are removing lifestyle commercials for alcohol from television, and removing licensed premises from highways.

Citing a 1983 federal government survey of attitudes among youth 15 to 24 years, he said they were "surprisingly traditional." Their most highly respected group in society was the police. Personal achievement was ranked first among principles or values by 84%, followed by respect for law and order by 70%. Sixty per cent were opposed to the legalization of marijuana.

Plants may hold clue to alcohol effect

By Harvey McConnell

WASHINGTON — Some of the biological effects of alcohol consumption may be related to estrogens derived from plant sources rather than ethanol, as is generally assumed.

Studies at the University of Pittsburgh, Pittsburgh, Pennsylvania, have shown that sexually-mature female rats who had their ovaries surgically removed still continued to show an estrogen response when fed non-ethanol bourbon. Judith Gavaler, a research associate, division of gastroenterology, department of medicine, described the research here at an Alcohol, Drug Abuse, and Mental Health Administration seminar.

Ms Gavaler said the research demonstrates that various estrogenic effects in the body which have been associated with consumption of alcoholic beverages may be due not to ethanol but to phyto-estrogens derived from plants, or a combination of ethanol and phyto-estrogen effects.

She points out that some of the estrogenic effects previously assumed to be linked to ethanol are increased levels of high-density lipoprotein cholesterol in the blood; and, with heavy drinking in women, an increased risk of breast cancer (editor's note: most breast cancer is considered estrogen linked), reproductive dysfunction, and early menopause.

Chronic drinking in men can lead to impotence and sterility. In addition, many of those with cirrhosis of the liver have a feminine physical appearance — suggesting high blood levels of the female sex hormone — but measurement of their blood estrogens show levels which are essentially normal.

Ms Gavaler noted that plant estrogens have been found in wheat, rice, and hops, among other plants, and in peanut, olive, soybean, and corn oils.

In their investigation they took bourbon, distilled from corn, and removed the ethanol by vacuum evaporation. The non-alcoholic bourbon was then put in the drinking water of rats whose ovaries had been removed. As the ovaries are considered the major source of estrogens in females, the non-alcoholic bourbon with its phyto-estrogens should elicit an estrogen response in the female rats. It did.

Ms Gavaler said they found that the weight of the treated rats' uterus and fallopian tubes significantly increased, instead of atrophying as they should without estrogen; and the levels of gonadotropin were significantly reduced, another signal of an estrogenic response.

"Thus, using two biological markers of an estrogenic response, we have demonstrated that non-alcoholic bourbon contains substances which are capable of producing an estrogenic response," she said.

In addition, experiments using receptors obtained from the uterus and liver showed that non-alcoholic bourbon interacts with these estrogen receptors in a manner similar to that of estrogens. Gas chromatography/mass spectrophotometry identified compounds in bourbon which have the chemical structure of known phyto-estrogens.

Ms Gavaler: "Findings of estrogenic substances in alcoholic beverages are important because it is possible that some biological effects of alcoholic beverage consumption may be related not only to ethanol but also to the presence of phyto-estrogens.

"Thus, in future studies, it will be necessary to evaluate disease processes from the standpoint of both ethanol and phyto-estrogen effects."

Talwin reformulation working: Senay

Ts and blues abuse dropping

ST LOUIS — Reformulation of Talwin (pentazocine) with the narcotic antagonist naloxone has dramatically reduced the incidence of "Ts and blues" use in the Chicago area, where the use of the combination by heroin addicts first surfaced in the mid-1970s.

Edward Senay, MD, professor of psychiatry, University of Chicago, in a report to the annual scientific meeting here of the Committee on Problems of Drug Dependence, noted that in the late 1970s many addicts injecting Ts and blues (pentazocine and tripelennamine) did not use heroin at all. In 1983 the manufacturers of Talwin reformulated the compound to include the narcotic antagonist naloxone (**The Journal**, Nov 1983).

In a study during the latter half of 1983, Dr Senay and colleagues at the University of Chicago drug abuse rehabilitation program evaluated 150 Ts and blues drug users. The mean age of the users was 33 and the mean age of first heroin use was 19.

During that period, the users rated the quality of the Talwin available as decreasing quite substantially. At the same time, there was a decrease in the quality of heroin available on the streets, said Dr Senay, who is also executive director, Substance Abuse Services, Inc, Chicago.

"We found that Ts and blues were no longer being used as the primary intoxicant, but were being used as a booster for poor-quality heroin," Dr Senay said. The users reported also a high incidence of dysphoric side effects from using reformulated Talwin tablets (which were nicknamed butterballs, bananas, or footballs).

It has now been a year since Dr Senay's clinic admitted drug abusers who complained primarily of Ts and blues use.

A report from the US National Institute on Drug Abuse said there has been a noticeable drop in Ts and blues abuse in other major US cities, including Detroit, St Louis, and New Orleans. The one city where there has not been a downward trend is Buffalo; drug users there have access to Talwin obtained from Canada where the drug has not been reformulated.

Some great moments in marketing and nature

By Wayne Howell

Pity the poor bird-watcher standing wet and cold in a rain-splattered marsh, his expensive binoculars fogged and useless, the bird he came to view nowhere to be seen. Personally, I prefer beer-commercial-watching as a hobby. You can practice it in the comfort of your own home, and it requires no special clothes or expensive equipment. All you need is the family television. Once you get involved in the hobby, you will want access to at least one good business publication, but for beginners *The Globe and Mail*'s Report on Business will do quite nicely.

To enjoy beer-commercial-watching, the neophyte need only know a few essential facts.

The first is that most people cannot tell the taste of one beer from another, just as most people cannot tell the differences between the 28 species of finches that inhabit the Galapagos islands.

The second fact is that there is an important minority of beer drinkers that consumes the majority of the beer produced — a minority that ranks rather low on "qualitative" socio-economic scales but impressively high on "quantitative" consumption scales. It is the beer advertiser's dream to touch the soul of this "hard-core" market, in the manner of the classic and legendary ad for Schaeffer's beer: "the beer to have when you're having more than one." (The hard-core tend to have more than one — this 20% of the beer-drinking fraternity consumes 80% of all the beer made.)

And the third fact is that there is a considerable, volatile swing-market of young "upscale" beer drinkers — both male and female — which is worth going after, provided you do not offend the hard core in the process.

Armed with these facts, the tyro beer-commercial hobbyist should have little trouble identifying beer commercials by their distinctive "video plumage" and should have no trouble "pegging the pitch" in terms of identifying the target market. But identification is just one aspect of the hobby — as it is in bird-watching. Aesthetic considerations are just as important. People like to look at wild birds because they are beautiful and demonstrate how nature has married form to function. They admire the thick, seed-cracking beak of the finch, the curved, meat-tearing beak of the hawk. A good beer commercial can also be a thing of beauty and a joy forever if, by means of sound, light, and color, it overtly or covertly succeeds in tickling all the right fancies of the target market. A great beer commercial descends on its target audience as silently and swiftly as an owl descends on a mouse. Only a few lucky bird-watchers have seen the latter phenomenon, but any beer-commercial-watcher can see the former if he hangs around televised sports events.

The business publication is of interest to the beer-commercial hobbyist because it is there that he will be able to validate his deductions and aesthetic perceptions through small items in the Marketing Section. And it is there that he will learn about new ad campaigns and new strategies. For instance, some time ago I read that Labatt's was preparing to introduce Budweiser to the Canadian market. Marketing executives were very concerned about the success of the venture because of the universal Canadian perception that United States beer is weak in alcohol as compared to its Canadian counterpart. (That perception is not true, but truth is not important in advertising; if Canadians thought that American beer was weak then something had to be done about it.)

How were the ad-men to handle the "weak beer" problem? As a veteran beer-commercial hobbyist, I mulled this problem over in my mind as I awaited the first Canadian "Bud" commercial with anticipation — the kind of anticipation a bird-watcher feels as he crouches in an inhospitable swamp waiting for the arrival of the first spring warbler.

Would the ad-men import Ed McMahon, the familiar Tonight Show spokesman for Bud, to allude by his weighty presence and reputation for copious consumption to the strength and manliness of the Budweiser brew? Or would they opt to do something more subtle — perhaps quickly-cut long shots of the thundering hooves of the Budweiser Clydesdales, the dust-churning equine tattoo a metaphor for Bud's intensity and power? How to say, softly and covertly, that you can get just as drunk on Canadian Bud as you can on Molson's Ex? I watched and I waited, knowing that some of the best minds in the country were struggling with this problem and searching for a solution. And when it came, it was so simple and elegant it almost made me weep.

First, the throbbing music and the attractive young people; then, a cut to a pan-shot of the Budweiser label, the camera caressing the curve of the bottle and the familiar Budweiser logo; and then, the sublime moment: a two second freeze-frame on the upper left-hand corner of the label, just time enough to burn '5% alcohol' into the viewer's brain, the highest alcohol content traditional Canadian beers contain. Subtle and elegant — so much so that when Carling O'Keefe countered with Miller beer, they couldn't improve on it, they did exactly the same thing.

Form married to function, function married to form — a great moment in beer-commercials, as beautiful in its own way as the mighty curve of a Great Blue Heron's wing. It is, isn't it?

NEWS

RESEARCH UPDATE

Straitjacket danger for LSD users

Placing patients who have become violent after taking LSD (lysergic acid diethylamide) in straitjackets can be a deadly combination. Jane Mercieca and Edwina Brown, Charing Cross Hospital, London, England, recently reported cases of a 25-year-old man who died and a 19-year-old man who became seriously ill after being placed in straitjackets prior to admission to hospital when they became violent after taking LSD. Both patients were diagnosed as having acute renal failure as the result of rhabdomyolysis (muscle disintegration). Despite the fact no other cases of this kind have been associated with the use of straitjackets, the researchers said it is possible the extreme violence demonstrated by some patients who have taken LSD, in combination with the severe restraint imposed by straitjackets, may precipitate the onset of rhabdomyolysis. "Thus," they concluded, "although it can be difficult to control such patients, even straitjackets cannot be used without risk."

British Medical Journal, June 30, 1984, v.288:1949-1950

Five-country study tests benefits of quitting

Pinpointing exactly what benefits accrue to smokers from reducing or completely giving up smoking has been one of the outcomes of a large case-control study of lung cancer in Western Europe. More than 7,000 lung cancer patients admitted to hospital in one of five Western European countries, and who had smoked cigarettes regularly, and 11,000 controls, who had smoked but had been admitted to hospital with diseases not related to tobacco, were interviewed to determine relative risks of developing lung cancer associated with several smoking variables. Researchers from the United States, Italy, France, Scotland, Austria, and West Germany found that the risk of developing lung cancer for people who had given up smoking 10 years or more before the interview was less than half of those who continued to smoke. After 10 years of abstinence, the risk of developing lung cancer for men who had smoked for less than 20 years was seen to approach that of lifelong non-smokers. Reducing the number of cigarettes smoked a day or switching from non-filter to filter cigarettes also lowered the lung cancer risk, but not to the extent seen with giving up the habit. The study concluded that "reducing the risk of developing lung cancer induced by cigarette smoking in middle aged and older smokers requires primary emphasis on stopping the smoking habit or lowering the amount smoked each day."

British Medical Journal, June 30, 1984 v.288:1953-1956

High-power benzos spark rebound anxiety

Patients being treated with benzodiazepines for anxiety can suffer powerful anxiety attacks sufficient to deter them from discontinuing the medication, if the drug is withdrawn abruptly. This is the finding of three Montreal researchers who studied 48 out-patients with anxiety in a double-blind, placebo-controlled investigation. After being drug-free for a week, patients received either diazepam, bromazepam (an intermediate-acting, high-potency benzodiazepine), or placebo for four weeks. In the following three weeks, the drug was either abruptly or gradually withdrawn. Of the 43 patients who entered the drug withdrawal phase, six (five in the abrupt withdrawal group) dropped out in the first week because of a rapid return of anxiety symptoms. Classifying rebound anxiety as an increase of 10% or more in two rating scales of anxiety, almost half of the patients whose benzodiazepine was withdrawn abruptly fitted into this group. There were no cases of rebound anxiety when the drug was withdrawn gradually. Five of eight patients on bromazepam suffered rebound anxiety compared to only two of eight patients taking diazepam. This greater risk seen with the newer, high-potency benzodiazepine may explain why the syndrome was not noticed earlier, the investigators said. They added that "dependence induced by other central nervous system drugs is caused primarily by drug tolerance, and physical symptoms occurring after drug cessation." In contrast, abrupt benzodiazepine withdrawal "seems to induce a transient rebound anxiety state in addition to minor physical symptoms."

American Journal of Psychiatry, July 1984, v.141:848-852

Parents' puffing means cough for kids

A definite link between coughs in young children and smoking by their parents has been shown in a British study. Anne Charlton, PhD, from the Manchester Regional Committee for Cancer Education, conducted a survey of 15,126 children between eight and 19 years old, detailing their own smoking habits and those of their parents and immediate family, as well as the self-reported incidence of coughs. In the group of children less than 11 years old who reported they had never smoked, 35% of boys and 32% of girls with no smoking parents reported frequent coughs. These statistics rose to 42% and 40% with one parent who smoked and 48% and 52% with both parents smoking. Other findings were that the proportion of children reporting frequent coughs decreased steadily with increasing age and that there was no apparent effect of parental smoking on the frequency of coughs reported by child smokers. Dr Charlton said the transfer of infections by the coughing of smoking parents might be the cause of respiratory illness and coughing by the children. She concluded that frequent coughs in children "present immediate as well as long term problems, absence from school and possible lung damage being only two of them."

British Medical Journal, June 2, 1984 v.288:1647-1649

Pat Rich

'Inalienable' right to smoke defended by Israeli group

By Michael Kesse

TEL AVIV — A "Smokers Association," aimed at defending the "inalienable rights" of people to smoke any place they see fit, has been formed in Israel.

The $10 annual membership fee will finance a campaign to repeal the recent law banning smoking in public places (**The Journal,** June, Nov 1983).

The association, which claims to be a serious lobby, has not yet revealed how many members it has enrolled.

The group is distributing stickers, two of them in the form of tombstones. One says: "I fell asleep while driving, because I gave up smoking — and I was only 20 at my death," and the other says: "I preferred to drink coffee as a stimulant and to give up smoking, so I died of a heart attack at the age of 30."

Another sticker shows a bus driver taking his eyes off the road to spot a smoker in the bus. The legend: "Dear driver — look at the road, and don't turn around to find a smoker. Our lives are in your hands."

The main argument of the association is that "3% of the population, perverted by a pathological hatred of tobacco, have forced the government to pass a law preventing the general public from enjoying itself." And if these "psychopaths" don't like, or can't bear, cigarette fumes, they should open a window, or go elsewhere.

The group claims the scientific evidence that tobacco is harmful is contradictory. Even that evidence which has shown that nicotine (and tars) are harmful is virtually meaningless, they say.

Bus drivers: watch road, not smokers

True, smoking shortens a person's life. But is it not better to live a few months less — and be happy, than live a few months more — and be miserable, the Smokers Association asks.

As for lung cancer, the group claims only 2% of the population (in Israel) die of it — and only one-fifth of these cases is the result of smoking. "It is healthier to smoke and be lean, than to stop smoking and become obese - for obesity is a greater killer than tobacco."

New class of drugs suggested

PPA dispensing needs monitoring

By Jon Newton

NEW YORK, NY — PPA (phenylpropanolamine) should be the first candidate for a new class of drugs available in the United States without a doctor's prescription, but only in drug stores where a qualified pharmacist personally oversees their distribution to customers.

Pharmacists would decide, using their "best professional judgment," that the patron has a "legitimate need for the product" and would have to be satisfied that the purchaser "understands the use of the product."

This was the recommendation of Albert Wertheimer, PhD, professor and chairman of the department of Social and Administrative Pharmacy, University of Minnesota, Minneapolis, speaking at the first conference on the risks and benefits of PPA at the New York Academy of Medicine, in June.

At the moment, all drugs in the US are available only over-the-counter (OTC), or with a prescription. There is no intermediate category such as the one suggested by Dr Wertheimer.

Last year, says Dr Wertheimer, 412,000 lbs of PPA were produced in the US, the vast majority for use in cough and cold remedies. Estimates of retail sales of such products came to about $1.3 billion. Although most contained PPA, there were few reports associated with medical or toxicity problems.

Spending for prescription drugs in the US in 1982 for all categories of outlets came to a total of $16.2 billion, said Dr Wertheimer. OTC drugs accounted for $3.3 billion in pharmacies.

But, since OTC products are also sold door-to-door, by mail order, in grocery stores, health and beauty departments, and so on, "we can assume a total OTC market at perhaps $7 billion or more," he estimates.

Diet and weight reduction markets are "big business" in the US, Dr Wertheimer says, and PPA is a common ingredient in many dieting aids. In 1982 more than $381 million was spent on the drugs in all outlets, with about $175 million (46%) going to drug stores.

". . . Firms spent nearly $40 million in advertising in 1983," he said. "People familiar with this market estimate that approximately 30% of sales revenue at the manufacturer's level is spent on advertising and promotion."

Broken down, the $381 million represents: reducing preparations, $228.8 million; metered calorie products, $62.3 million; synthetic sweeteners, $61.3 million; and powder, liquid protein preparations, $28.8 million.

Dr Wertheimer said there are nearly 30 US entrants in the huge $229 million OTC "reducing preparation" market.

PPA is widely available overseas also, he said. Only The Netherlands, Denmark (and Canada) do not market PPA for weight reduction, but it is available OTC in England, France, Greece, West Germany, Italy, Japan, Korea, Singapore, Spain, Thailand, the United Arab Emirates, and the US.

It is available by prescription only in Australia, Austria, Djibouti, Finland, Hungary, Israel, Malta, New Zealand, Norway, South Africa, Sweden, and Switzerland.

Described in detail, this means:

North America

- US — available alone OTC, or in diet and cold preparations,
- Canada — not available alone, but available in combination OTC or by prescription.

Western Europe

- United Kingdom — OTC cold preparations in a maximum dose of 50 milligrams, with a maximum daily dose of 150 mg,
- France — OTC only in combination cold products,
- Spain — OTC and prescription drugs, but not for diet purposes. OTC diet products include protein, carbohydrate, vitamin, mineral, and fibre combinations,
- West German — OTC for dieting, but advertising is not supposed to be directed to the general public. Warnings must appear on product packaging,
- Austria — on prescription in rhinitis formulations only,
- Denmark — not available,
- The Netherlands — only in 10 m nose drop packages,
- Switzerland — only in combination for respiratory problems,
- Malta — not available OTC,
- Greece — OTC as a nasal decongesant,
- Norway — by prescription only as a nasal decongestant alone and in combination.

Eastern Europe

- Hungary — by prescription only, but not for dieting,
- USSR — not available OTC.

Asia

- Japan — OTC combinations for coughs and colds, with a dosage limit of 90 mg per day,
- Korea — available as an OTC diet product,
- Taiwan — in combination OTC products for coughs and colds, and alone in prescription products,
- Thailand — "higher security" OTC category only in pharmacies, alone and in combination.

Middle East

- United Arab Emirates — OTC and by prescription, but cannot be advertised to the public for diet usage,
- Djibouti — OTC in decongestant products only, in combination with other ingredients,
- Israel — not available except in cold product combinations.

"It appears that PPA is an ingredient in numerous cough and cold preparations in most countries around the world," added Dr Wertheimer. "In addition, the dieting market only exists in a limited number of nations.

"Overweight/obesity are rarely encountered conditions in much of Southeast Asia, Africa, and parts of Central and South America.

'Therefore, one must keep in mind the fact that the lack of diet products on the market in many countries indicates an insufficient market for the product as much, if not more than, any regulatory actions."

Caffeine:

history, habits, and health

First of a two-part series

Caffeine consumption by the world's population amounts to some 120,000 tonnes a year in all, or 70 milligrams a day per capita — the equivalent of a daily large cup of instant coffee or a small cup of drip coffee for each person on earth. About 54% of this caffeine comes from coffee. Another 43% comes from tea (**The Journal**, Nov 1983). In this two-part review, I'll give a brief account of the history and place of caffeine in society, touch on some of the rapidly growing literature on the subject, and attempt to explain why so much of this drug is used and what can happen to people who use too much of it.

The literature on caffeine is indeed growing. Some 500 medical and scientific articles on caffeine are now being published each year. Researchers interested in a broad understanding of caffeine's place in society should also keep an eye on the hundreds of items produced annually on the cultivation of coffee, tea, and other caffeine-yielding plants, on the trade in coffee beans, tea leaves, kola nuts, etc, and on the production, marketing, and use of caffeine-containing beverages.

Caffeine's importance

Readers of **The Journal** can have at least four reasons to be concerned about caffeine:

- Caffeine is a psychotropic drug — ie, a chemical taken at least in part for its effect on the user's mood, as is alcohol, nicotine, cannabinol, cocaine, and the other substances of particular concern to drug-abuse professionals. Knowledge about the use and abuse of caffeine can contribute to our understanding of the use and abuse of all psychotropic drugs.
- Caffeine interacts with many psychotropic drugs to enhance, reduce or otherwise alter their effects. Because caffeine is used by most drug abusers, knowledge of caffeine's interactions can be important for a full understanding of any client's drug abuse.
- The consequences of excessive caffeine use are themselves matters for medical and psychological concern.
- The extent to which concern about caffeine is justified is very much a matter of controversy. Medical and scientific debate can provide good opportunities for clarifying assumptions, concepts, ideas, and notions in a field known for its unclarity.

There was a session on caffeine at the 4th World Congress for the Prevention of Alcoholism and Drug Dependency, held in Nairobi, Kenya in September 1982. The speaker, nutritionist Dr Patricia Mutch of Andrews University, Berrien Springs, Mich, said that "individuals interested in educating our youth against addictive and harmful drugs" should note that "caffeine is a candidate to be added to the list of drugs to be avoided or used in extremely conservative amounts."

By contrast, psychiatrist and psychopharmacologist Dr Peter Dews of the Harvard Medical School, Boston, concluded a 1982 review of caffeine with this: "It is surely true that people harm themselves, their performance, and perhaps in other ways, with excessive intakes of caffeine; but gross over-consumption of any article of diet can be harmful. The deleterious effects of excess intake of caffeine, within some limit, seem to be transient and completely reversible."

A middle position was taken by Australian psychiatrist Dr John Couper-Smartt and food technologist Islay Couper-Smartt in an article published this year: "The symptoms of caffeine intoxication are becoming increasingly recognized by the medical profession, the general scientific population, and the lay press. The symptoms of caffeine toxicity are seen in a wide variety of medical conditions, and patients suffering from hypercaffeinism present themselves to cardiology, neurology, psychiatric, general practice, and gastro-enterology clinics yet patients come to accept their sleep problems, irritability, fidgetiness, and other symptoms as 'normal.' They often find it difficult to accept that there may be a link between their symptomatology and a long-established (and socially acceptable) pattern of beverage abuse. Awareness of the condition will lead, however, to its rapid diagnosis and rational treatment."

Caffeine's chemistry and biochemistry

Caffeine was first isolated from coffee in 1820 and from tea in 1827. The caffeine in tea was thought to be a different compound. It was given the name *theine*. The identity of theine was soon recognized, as was the fact that the mood- and behavior-altering properties of both coffee and tea depend on caffeine.

Pure caffeine is a white powder resembling baking powder but extremely bitter to the taste. Its technical names are 3,7-dihydro-1,3,7-trimethyl-1H-purine-2,6-dione and, more commonly, 1,3,7-trimethylxanthine. The latter name indicates that caffeine is structurally the chemical xanthine with a hydrogen atom replaced by a methyl group (a carbon and three hydrogen atoms) in three places. Caffeine shares two methyl groups with each of two pharmacologically active dimethylxanthines — theophylline, which is found in much smaller quantities than caffeine in tea, and theobromine, which is found in much larger quantities than caffeine in cocoa. Both dimethylxanthines are found in human urine after caffeine use, but in lesser concentrations than the third dimethylxanthine, paraxanthine, which is the primary metabolite of caffeine found in plasma.

The various xanthines are structurally related to many important chemicals in the body including uric acid, the unusually high levels of which in humans are believed to contribute to their longevity, and adenine and guanine, which are part of the DNA molecule and constitute two of the four elements of the genetic code. Caffeine is known to bind with DNA, to inhibit DNA and RNA synthesis, and to cause chromosomal aberrations in plants and animals.

Caffeine is also structurally similar to adenosine, a chemical found in the spaces between cells throughout the body and whose actions are now believed to be central to an understanding of caffeine's effects. At first sight, adenosine appeared to be merely an intermediate product or by-product of some of the body's many metabolic processes. Researchers now believe that adenosine may be an important regulator of central and peripheral neural transmission. Injection of adenosine or substances that increase circulating adenosine levels can cause lethargy and sleep. Adenosine can also reduce heart rate, blood pressure, and body temperature, induce vasodilation, diminish gastrointestinal motility, protect against seizures, and attenuate the responses of various organ systems to stress.

According to Drs Neims and von Borstel of the University of Florida, Gainesville, "Over the past decade, considerable evidence has been marshalled that supports the hypothesis that the physiologically most important action for methylxanthines involves competitive antagonism at extra-cellular adenosine receptors." Adenosine depresses neural activity by inhibiting the release of chemicals that carry messages from one nerve cell to another. To do this, adenosine must first bind to specific receptors on the cell surface — of which there appear to be two kinds. The current explanation of caffeine's action is that it binds to both kinds of receptor, prevents adenosine from binding there, and thus allows the nerve cells to fire more readily.

Caffeine is moderately soluble in water; more soluble complexes with sodium benzoate and citric acid are used for injections — each providing about 50% of the drug. Caffeine is not ionized at physiological pH. It is sufficiently hydrophobic to cross biological membranes with ease. Drs Neims and von Borstel noted that: "These physiochemical properties are largely responsible for several of caffeine's important metabolic characteristics:

- rapid and complete absorption from the gastrointestinal tract;
- rapid, yet passive distribution to all organs including all organs of the fetus;
- inefficient excretion by the kidneys; and,
- dependence on biotransformations for efficient elimination from the body."

Sources of caffeine

Caffeine is found naturally in some 63 species of plant, but two species of coffee and one of tea provide 97% of the caffeine used. The coffee species are *Coffea arabica*, native to Ethiopia but now cultivated chiefly in Brazil and Colombia, and *Coffea robusta*, native to Saudi Arabia but now cultivated chiefly in Indonesia, Brazil, and many parts of Africa. The tea species is *Camellia sinensis*, native to China and India and still cultivated chiefly there.

Only one other species of the coffea genus has had commercial significance — *Coffea liberica* — and no other species of the camellia genus. Wild species of both genera abound — of coffea in Africa and of camellia in the Yunnan province of China, where a 1,800-year old plant more than 30 metres high has been reported.

Other commercially-valuable plant sources of caffeine are cocoa beans, kola nuts, maté leaves, guarana seeds, and yoco bark. The first two are produced mainly in Africa, the remainder in South America. Only maté is consumed in any quantity, and then only in Paraguay, Uruguay, and Argentina.

Guarana seeds are the richest source of caffeine —more than 4% by weight. Tea leaves contain about 3.5% caffeine. Robusta coffee beans contain about 2% and Arabica beans about 1% caffeine. Practice varies widely but, on average, tea beverage is made with four times as much water per weight of leaf or bean as coffee. Thus a cup of coffee, as consumed, contains roughly twice as much caffeine as a cup of tea.

Caffeine may be synthesized in the laboratory in a variety of ways. None is as commercially viable as extracting it from coffee beans or tea leaves. Such extraction, particularly during deliberate decaffeination of coffee and tea, provides all the caffeine that is used in medicines and added to soft drinks. A small amount of the caffeine in soft drinks comes from kola nuts.

History — tea

Continuous records of tea use in China date back at least 1,600 years and perhaps 4,700 years. Tea use spread with Chinese culture to Japan around 600 AD, but it took 700 years for it to become a central feature of Japanese life. Dutch traders brought tea back with them in the 17th century. Its use spread throughout Europe often displacing coffee even though the price of tea was initially much higher. Throughout, tea appears to have been used in the form of a hot beverage and also as a medicine.

Tea took a particularly strong hold in the North American colonies. American women were "such slaves to it," wrote one tourist in the 1760s, "that they would rather go without their dinners than without a dish of tea." The British government put a special tax on tea and other items in 1767. Strongly supported by local medical and ecclesiastical opinion, American colonists boycotted tea and burned and dumped cargoes of it in harbors along the East coast, notably at Boston, in December 1773.

The Boston event was duly recorded in British newspapers a month later, not so much for its political significance as for its effect on the unfortunate fish in the harbor who took in a hefty dose of caffeine and "contracted a disorder not unlike the nervous complaints of the body." The United States became a coffee-drinking nation.

Through the East India Company, the British had the world monopoly on the tea trade. With the expiry of the treaty with China in 1833, the British position became increasingly insecure. Much of the rest of the century was spent in developing tea plantations in the Indian subcontinent, eventually using native Assam varieties of *Camellia sinensis*, although in the 1870s still more than 90% of Britain's tea came from China.

The insecurity of Britain's hold on the tea trade was not helped by a tax on tea that, in the early 19th century, was 15 times higher than the tax on coffee. Probably as a consequence, coffee use in Britain went from being one-twentieth of tea use in 1800 to being equal to tea use in 1840. Then, a series of coffee-adulteration scandals gave tea the edge — chicory, roasted corn, vegetable roots, baked horse liver, and various dyes were used — aided by more realistic taxing practices. Tea became the British beverage.

History — coffee

Coffee was first mentioned in writing in Arabian documents of the 10th century, but there is evidence that it was cultivated in Ethiopia in the 6th century. Then the coffee berries were chewed. Later their fermented juice was used to make a wine.

(Nineteenth-century explorers reported that coffee berries were still being chewed, never used in infusions, in tropical Africa, where there was widespread cultivation of coffee trees for this purpose.)

By the end of the 17th century the Dutch had established coffee plantations in Java. During the next 50 years the French first and then the British followed suit in their Caribbean possessions, from which the commercial cultivation of coffee spread to Central and South America. Brazil supplanted Indonesia as the major exporter of coffee in the early part of the 19th century. By 1860, the US was consuming three-quarters of the world's coffee, more than half of which came from Brazil.

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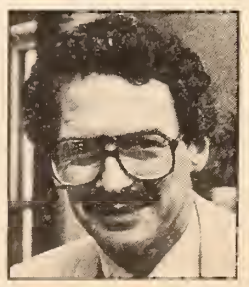
By Richard Gilbert, PhD



For information on sources used in this series write the author, c/o The Journal, Addiction Research Foundation, 33 Russell St, Toronto, Canada M5S 2S1

(from page 5)

Trade in coffee and tea

About 20% of coffee production and 50% of tea production is retained for local use. The remainder is exported.

Coffee is exported chiefly from Brazil (about 20% of the total), Colombia (15%), and the Ivory Coast (7%). The chief importers are the US (30%), West Germany (12%), and France (9%). Coffee is second to crude oil as an earner of foreign exchange for developing countries. It is North America's major agricultural import.

Caffeine

Trade in coffee is conducted mostly under the auspices of the International Coffee Organization, which comprises 73 members — 48 exporting countries, and 25 importing countries. These countries are party to the International Coffee Agreement, which sets quarterly export quotas and regulates other aspects of the coffee trade. A new six-year agreement was signed in October 1983. Its main objective is to keep the price of a kilogram of green coffee beans within a range that is currently the equivalent of $2.65 to $3.10 (US). Specified amounts may be released from stocks — at present totalling 3.6 million tonnes, equivalent to one year's trade — when the price of a 60 kg bag rises above $191.40 (actually stated as $1.45 a pound). This year the price has been hovering above the trigger point, with consequent releases from stocks.

Overall, about 27% of the trade in coffee comprises the inferior and relatively caffeine-rich Robusta beans. The remainder consists of Arabica beans of a wide range of qualities. Countries differ greatly in the proportions of each type of bean imported. For example, 58% of the bean imported into France is Robusta, whereas this type comprises less than 10% of the coffee bean imported into West Germany. Such differences must be taken into account when using trade data to compare caffeine use among countries.

Tea is exported chiefly from India (typically 26% of the total, although less this year because of a partial export ban), Sri Lanka (typically 22% of the total), and China (11%). India and China are respectively the major producers but retain much of their crop for local use. The major importing countries are Britain (23% of the total), the US (9%), and the USSR (8%). The tea trade amounts in value to about one-sixth of the value of the trade in coffee.

Trade in tea has not been regulated since the 1930s — except by the market factors of supply and demand, and occasional restrictions by governments of individual exporting countries. Contributing factors to the lack of regulation are demand that usually runs ahead of supply, meaning few battles over prices, and the problems of storing tea for more than a few months, which make it difficult for exporters to control the market by holding back stocks or releasing them. Opponents of regulation suggest that it is unnecessary because tea prices have been very stable compared with other commodities. Now, however, tea prices are at record levels and rising at close to the rate of 100% a year. Discussions about a possible new International Tea Agreement continue at the United Nations Food and Agriculture Organization in Rome.

Caffeine consumption and marketing

I reviewed recent trends in caffeine consumption, particularly in North America, in my November 1983 column. There I noted, among other things, that on a per capita basis Canada is now ahead of the US both in coffee and tea use and in overall caffeine consumption. Both countries use caffeine at a rate that is about three times the world average, but at only half the rate of the countries with the highest consumption such as Sweden, a predominantly coffee-drinking country, and Britain, where tea is preferred but coffee is catching up.

The substantial decline in per capita coffee use in the US — 36% since 1960 — has occurred mostly among young people. In 1962, coffee use by 20 to 24 year olds was 98% of the national average, but only 48% in 1982; whereas use by 60 to 69 year olds was 96% of the average in 1962 and 139% of the average in 1982. According to a vice-president of General Foods Corporation, the coffee industry's problem is ". . . a young generation who find coffee irrelevant to their lives except for an occasional wake-up cup . . . a perception among young adults that coffee is for old, tired, frazzled, uninteresting, unsexy people."

Young people in the US are drinking soft drinks, consumption of which has almost quadrupled there since the early 1960s. Humans take in an average of roughly 500 litres of liquid a year. In the US nearly a third of this total is now ingested in the form of soft drinks — twice the Canadian intake of soft drinks. Children and teenagers consume half of the total volume of soft drinks. Thus, in the US, well over one-third of liquid ingested by young people is in the form of soft drinks.

Close to 85% of all soft drinks consumed in the US in 1982 contained caffeine, an average of 35 mg per 12-ounce serving. Since then, caffeine-free versions of what were previously caffeinated soft drinks have been introduced, capturing typically 7% of the market. Young people have been found by advertisers to be less concerned about caffeine than adults.

Advertising for soft drinks appears increasingly directed to young people. Annual expenditures in the US on the two leading brands, both of which contain caffeine, exceed $80 million. This year's budgets include millions spent on sponsoring concerts by rock stars Duran Duran (Coca-Cola) and Michael Jackson (Pepsi-Cola). In third place in sales is Seven-Up, which is heavily advertised in ways that stress its lack of caffeine.

Fourth place in sales of soft-drink brands is occupied by Dr Pepper. Advertising for this caffeine-containing beverage is now being aimed at 'inner-directed' young people. A Dr Pepper executive explained: "We currently see 30% of the young population as being inner-directed. Our projections indicated inner-directeds will make up 60% of that population by 1990."

Faced by this continuing onslaught, the coffee industry is fighting back in kind. A generic advertising campaign was launched in the US in September 1983 under the auspices of the National Coffee Association. It features rockstar David Bowie and other "Coffee Achievers" likely to appeal to young people. Coffee is being characterized as "The Think Drink." Industry surveys indicate that 50% of young people are aware of the campaign.

The industry is aggressively countering claims of caffeine's ill-effects and promoting its benefits. Some of the ads' claims are being challenged. A petition protesting the claim that "coffee lets you calm yourself down — and picks you up" has been filed by the Washington-based Center for Science in the Public Interest with the US Federal Trade Commission. A similar claim — "You are the new coffee generation because coffee lets you calm yourself down and picks you up" — has been investigated by the US Council of Better Business Bureaus.

Reasons for caffeine use

Most of the known caffeine-yielding plants were probably discovered and used in paleolithic times. It is reasonable to speculate that the chewing of the seeds, bark, and leaves of such plants became associated with the resulting mood changes, and that the plants were sought out and then cultivated for their ability to banish fatigue, prolong wakefulness, and otherwise elevate mood. Pastes were likely made to aid digestion and make the material more manageable. Then may have followed the discovery that greater potency as a mood changer could be achieved by using hot water — actually on account of the greater solubility of caffeine. It is thus easy to speculate about the origin of the caffeine-containing beverages whose present or recent use is known, including maté, guarana, yoco infusion, cassina, and kola tea, as well as coffee, tea, and cocoa.

Many of these beverages were used for their supposed medicinal properties, tea in particular. Tea merchants in England in the 17th century imported not only the leaves from China and Japan but also a list of maladies against which tea was believed to be a specific — migraine, apoplexy, paralysis, vertigo, epilepsy, catarrh, colic, gallstones, and consumption.

The taste of coffee and tea is intrinsically unpleasant. It becomes pleasant with experience, perhaps aided by association with the desired mood-changing consequences of using caffeine. Considerable cultural differences in beverage use exist in both the US and Canada, suggesting a strong effect of early experience. Americans of Italian origin, for example, drink more coffee than black Americans and are much more likely to have used coffee as children.

There is much in coffee and tea that allows for the development of use on the basis of taste. At least 610 volatiles have been identified in roasted coffee, and 360 in tea.

Coffee appears to have at least one other pharmacologically active substance, identified as an opiate antagonist capable of producing changes in mood (**The Journal**, Aug 1983). Conceivably, use of decaffeinated coffee is sustained by the effect of this unidentified substance, as well as by an acquired liking for the taste.

The basic reason for the popularity of caffeine-containing beverages is, however, caffeine. This has been demonstrated experimentally by reducing the caffeine content of coffee and noting that coffee drinkers drink more of it in compensation. The caffeine is ingested not only for its beneficial effects on mood and behavior but also because it alleviates the withdrawal syndrome that occurs when regular use of coffee is interrupted.

Caffeine's beneficial effects

Coffee drinkers have been found to say the following things about their preferred beverage, in order of emphasis:

1. It gives you a feeling of well-being.
2. It calms your nerves, makes you relax.
3. It helps you think, it helps orient you.
4. It makes you less irritable.
5. It wakes you up, gets you going.
6. It reduces or avoids headache.
7. You would feel bad without it.
8. It stimulates you, gives you energy.

Of these reported effects, only the third and eighth are clearly independent of the caffeine withdrawal syndrome, of which more below.

Experiments to test the effects of caffeine on mental and physical activity have yielded a variety of results.

In the case of mental activity, differences have been found according to the type of subject. For example, caffeine has been found to reduce the number of proof-reading errors made by impulsive subjects, but not by other subjects. A different study showed that this difference occurred only in the morning; in the evening impulsive subjects were helped less by caffeine than other subjects. Subjects classed as extraverts are helped more in such tasks by caffeine than subjects classed as introverts. At more than low doses — ie, at the equivalent of more than one cup of coffee — the performance of introverts may be retarded.

What may be happening here is an interaction between the drug and the basic arousal level of the subject. One theory is that impulsive or extraverted people are compensating for a low arousal level, especially in the morning. Caffeine raises the arousal level reducing the need for the 'extra' behavior that interferes with appropriate action. Introverts, by contrast, are excessively stimulated by caffeine and perform poorly with the drug, except perhaps in the evening when their arousal level is low.

The effects of caffeine on physical activity appear to be more consistent: the drug has usually been found to facilitate performance, particularly where endurance is required. The effect seems stronger when the work load is constant rather than increasing, at high altitude, and at normal rather than low temperatures.

How caffeine enhances physical performance is unclear. The drug is known to raise the energy expenditure of the body at rest — by 16% after a 100 mg dose in one study — and during exercise. It is unclear whether caffeine-enhanced endurance results from prolonged rapid stimulation of motor nerves, from facilitation of neuromuscular transmission, from increased mobilization of free fatty acids, or from some combination of these effects.

In 1962, caffeine was classified as a 'doping agent' by the International Olympic Committee, but it was later removed from the long list of drugs banned for Olympic contenders.

Dependence on caffeine

Physical dependence on a drug is said to occur when interruption of chronic use produces a characteristic withdrawal syndrome. In 1981, Dr Louis Roller reported the progress of the syndrome in a male, heavy coffee drinker whose average caffeine intake was in the order of 1,000 mg a day and who abstained from caffeine for 72 hours in a series of trials.

Roller found that symptoms commenced at six hours and then increased in intensity for the rest of the period. A headache developed first, followed by tiredness or lassitude, a runny nose, leg pains, sweating, and then, at 16 hours, general muscle pains. Coffee containing 115 mg of caffeine abolished all symptoms, but decaffeinated coffee did not.

Other work suggests that adults may be dependent on caffeine when their regular intake is as little as 350 mg a day — ie, the equivalent of three or four moderately strong cups of coffee. More than 20% of the adult population of North America uses this amount. Thus, it is reasonable to suppose both that many of the eight reported effects of caffeine use listed above are actually relief of withdrawal symptoms, and that much caffeine is consumed for this purpose.

Effects of caffeine on health

A major review in 1981 by the American Council of Science and Health, and another by Drs Peter Curatolo and David Robertson in 1982, support the view that regular consumption of moderate amounts of caffeine (ie, less than 300 mg a day) is not a threat to the health of adults. The conclusion of the latter review is a succinct summary of much of the available evidence:

"The overall effect of caffeine on health is difficult to assess. Acutely administered caffeine has been shown to increase blood pressure, plasma catecholamines, plasma renin activity, serum free-fatty-acid levels, urine production, and gastric acid secretion; and to alter the EEG spectra, mood, and sleep patterns of normal volunteers. Chronic consumption of caffeine by normal subjects has no effect on blood pressure, plasma catecholamines, plasma renin activity, serum cholesterol, blood glucose, or urine production. The effects of caffeine on cardiac output and stroke volume, basal metabolic rate, respiratory rate, or small intestine function have not been adequately studied. Among the indications for which it has been proposed, caffeine does not appear to be therapeutically useful in the artificial insemination of hypomotile sperm, in the therapy of minimal brain dysfunction, cancer, or Parkinson's syndrome; however, caffeine may be useful topically in the therapy of atopic dermatitis and systemically in the treatment of neonatal apnea. The consumption of coffee or caffeine-containing beverages does not appear to be associated with myocardial infarction; lower urinary tract, renal, or pancreatic cancer; teratogenicity; or fibrocystic breast disease. The role of caffeine in the production of cardiac arrhythmias or gastric or duodenal ulcers remains uncertain. Because caffeine is the most widely consumed drug in Western society, further enquiry into its health consequences is clearly needed."

Next month I shall elaborate on some of caffeine's effects and potential effects on health.

NEWS

Manitoba lesson plans 'tune kids in to health'

Students playing games to learn drug risks

By Maureen Brosnahan

WINNIPEG — Students in Manitoba elementary schools will be introduced this fall to a program aimed at developing responsible attitudes to drug use.

The program, called Tuning In To Health, was developed by the Alcoholism Foundation of Manitoba (AFM) with the support and endorsement of the province's department of education. It's designed as a prevention program that originators hope will lead to a decrease in the future use or abuse of substances.

Ross Ramsay, executive director of the AFM, said the "Early Years" phase of the program is designed for grades 2 and 3 pupils who will learn to identify household medicines and hazardous products and how they should be used responsibly.

A second part, "The Middle Years," is directed to grades 4, 5, and 6 and deals with decision-making involving smoking, mood-altering drugs, and alcohol.

Mr Ramsay told **The Journal** some of the lessons are taught using special games. "It's designed to give content and knowledge to students while they're having fun."

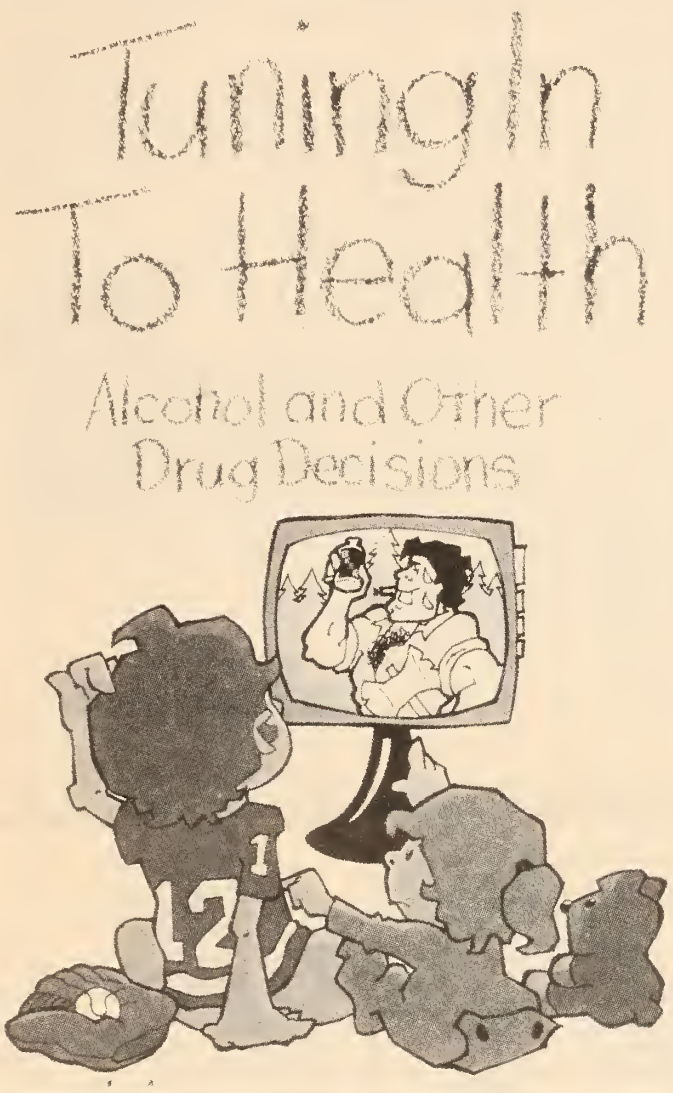
For example, a board game, "Risks and Routes" allows students to find out how various drugs enter the bloodstream and what effects they have on the way through the body. As players pass through the "snakes and ladders" type maze of bodily organs and blood vessels, they can gain demerit points for bad decisions on drug taking or lose demerits for "changing lifestyle" or knowing the facts about drug risks.

The Tuning In program is being introduced as an optional part of a new health curriculum developed by the Manitoba department of education. Mary Brown, health consultant for the department, said the program fits in with the other health topics and meets the needs and interests of the children.

Mr Ramsay said it will take about three years to phase the program into the elementary schools. However, he said the initial response has been so positive government officials have already approached the AFM about developing a third section for junior high school students. He said this is already underway but will take about two years to complete.

"We are the first province to have a program done which is curriculum-based and approved by the department of education," Mr Ramsay said.

However, officials were cautious in their plans for the Tuning In program, which cost about $500,000 to develop, following the controversy surrounding the introduction of a similar program in Manitoba in 1979.



Manitoba package: content and knowledge while they're having fun

That program, called Building the Pieces Together, provoked outcries from parents and some school officials who believed it was too addiction-specific and was imposing values rather than providing information. The controversy resulted in the program being withdrawn.

Mr Ramsay said he's confident that the Tuning In program will not meet the same fate. The program was piloted early last year in 26 schools throughout rural and urban Manitoba, and responses were favorable, he said. Since then it has been revised, following the recommendations from the study.

As well, the AFM is holding information meetings with parents and school officials to explain the program.

"Everything we've checked this time says we're going to be okay," Mr Ramsay said. "We're so confident, given the analysis . . . I'd really be surprised if we got into any problems with the program."

Denise Koos, AFM's prevention coordinator who also helped develop the Tuning In program, says there's been much more cooperation between the various groups this time. "I think we're being cautious but we are seeking community support," she said.

The course will be taught by the classroom teacher who will be given a three-hour in-service training program first.

Ms Koos says 42 of the province's 51 school divisions already have trainers in their areas to teach the other teachers.

Mr Ramsay says he believes the classroom teacher will be much more effective in getting the information across than someone visiting the class on a sporadic basis.

"Those teachers develop a rapport (with the students) over the years that we could never hope to develop," he said.

Mr Ramsay said Tuning In has already prompted interest across Canada and the United States. "The material has gone to every province in Canada and the two territories," he said.

Parental consistency is key to anti-drug approach with teens

By Betty Lou Lee

HAMILTON — Parents of children abusing alcohol or other drugs must be consistent and united in their approach. Too often they alternate between a tough stance for days and weeks, and indulgence, when they try to make deals, says Don Smyth, a substance abuse consultant to the Ottawa School Board.

"Once a young person gets to the stage of abuse (not addiction), it is extremely difficult to turn it around," said Mr Smyth, who also operates concerned parents groups in Toronto and Ottawa and was former youth programs director for Alcohol and Drug Concerns, Inc.

Golobitsh

Personal contact: important

The chances are poor if the parents are divided in their approach, if they aren't prepared to examine their own use of drugs, or if there is an absent parent who has an abuse problem.

He suggested parents keep records of their child's abuse, with dates, times, significant events, and behavior. These records can not only be used in confronting the child, but also may point to a pattern.

One girl, for example, would abuse drugs every time her parents talked about separating, as a way of keeping them together, Mr Smyth told the Institute on Addiction Studies here.

Personal contact with teachers is also important; in person, they may give a quite different picture than the one implied by computer-designed comments on report cards.

Parents should seek professional counselling, or the help of a group with one set of directions, Mr Smyth said, but they shouldn't expect a professional "to sort it out in a couple of weeks.

"Many eventually give up, and go for deal-making, which is a very unwise move. But many are living lives of pure hell."

He suggests parents start "with a declaration of unconditional love," but a firm stand that they cannot accept the drinking or drug use and won't support it in any way.

Subsequent stages are identifying the consequences of continued use, heightening those consequences, and identifying payoffs. Both consequences and payoffs will vary with the child and the situation.

Mr Smyth said a number of factors are common among 137 abusers aged 14 to 18 with whom he has been involved. There is often anger and rage, particularly toward an absent parent who doesn't care. Almost all had been diagnosed as hyperactive in early childhood, and many had a parental history of alcohol or drug abuse.

He noted that although we are getting into the third generation since the advent of street-drug use, there is little research on the effects of earlier parental drug use on children.

Family dysfunction, fear of failure, and depression are other common factors.

Auto club kit helps kids make alcohol decisions

By Betty Lou Lee

HAMILTON — Kindergarten children are a long way from driving cars, but they are not too young to start developing attitudes about alcohol.

So the Ontario Motor League (OML) is now working to extend its student education efforts down to that level, using the Starting Early program developed late last year by the American Automobile Association in the United States.

It's a kit of games, filmstrips, puzzles, lapbooks, and trigger films geared for each school year from kindergarten to grade 6, with a teacher's guide for each level.

Pat Curran, manager of consumer and public information with the Toronto club of the OML, says the kit is now in all City of Toronto schools, the Hamilton club has held two training classes for teachers, and an assortment of other club members of the Canadian Automobile Association are becoming involved.

The kit costs $25, and one can serve a whole school.

Explaining it at the 25th annual Institute on Addiction Studies held here by Alcohol and Drug Concerns, Inc, she said: "The young mind is the place to start. Kindergarten to grade 6 is the time when attitudes can be developed . . . We do know that at age five, children are aware of what beer, wine, and liquor are . . . one survey showed 145 uses of alcohol in prime time television."

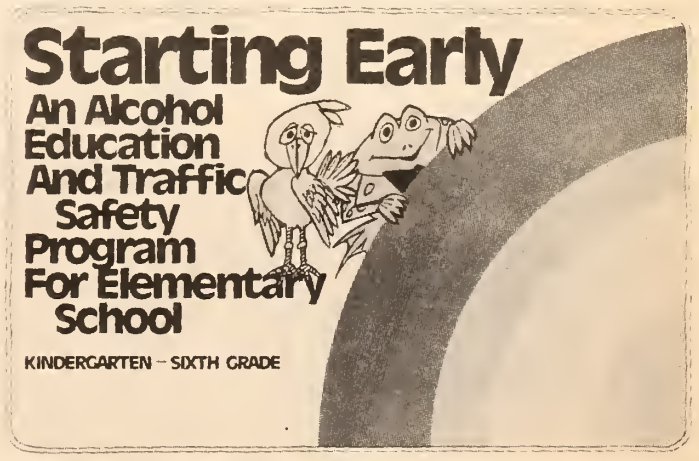
A 1976 US department of justice report showed 271 children 10 years old or younger were arrested for liquor law violations, and 50 of them were driving under the influence of alcohol. Another US study showed 45% of children in grades 4 to 6 use alcohol — 8% of them at least once a week, she said.

At the kindergarten level of Starting Early, children draw their own "shadows" with an outline tracing of their bodies, then select healthy things to put in their shadows.

By grade 2, Froggy and Do-Do (a bird) get into the beer left in a discarded can and discover that neither can fly.

In grade 5, a game is geared to working out the effects of two beers on several imaginary animals. A film of a party shows what happens when alcohol is, and isn't, involved.

Trigger films for discussion are part of the grade 6 curriculum and deal with several situations where decisions about drinking must be made.



The young mind: the place to start

The Journal

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Correction fluid death

Victim's uncle seeks evidence on hazards

On June 16, 1984 in Santa Rosa, California, my 13-year-old niece died from the inhalation of typewriter correction fluid.

I am currently contacting California state legislators in order to have typewriter correction fluid placed in the same category as airplane model glue, which in order to purchase in California you must be 18 years old. Also, it is only available on request at the checkout stand.

Any information or documentation you can provide me would be greatly appreciated and useful in my attempt to get this tragic, new, and cheap thrill out of the hands of children.

Dan "D. G." Williams
Attorney-at-Law
800 H Street, Suite 304
Sacramento, California 95814

Editor's note: Readers of The Journal are invited to respond to Mr Williams directly, or through the Letters to the Editor column.

Stay Real info sparks interest

We refer to the article, Parents' response 'phenomenal' to offer of marijuana info, in the June 1983 issue of The Journal.

We would be very grateful to have more details relating to this program, and, if possible, to have a copy of the above-mentioned booklet. Let us know if there are any costs involved.

Your cooperation in this matter will be greatly appreciated.

Mrs E. Van Der Merwe
Secretary/Librarian
for Director Information and Prevention
South African National Council on Alcoholism and Drug Dependence
Johannesburg

Editor's note: For information about the 'Stay Real' program write to:

Joyce Henderson
Health Promotion Directorate
Health and Welfare Canada
Ottawa, Ontario
K1A 1B4

The Journal, June 1983

Phenomenal response

Research focus of Children of Alcoholics conference

In April 1984, The Children of Alcoholics Foundation held its Conference on Research Needs and Opportunities for Children of Alcoholics. It brought together 18 leading research and clinical authorities to develop an agenda and strategies for future research directions.

The conferees, who were greeted by Joseph A. Califano, Jr, former United States Health, Education and Welfare Secretary and Honorary Trustee of the Foundation, included John R. DeLuca, Drs Jon M. Aase, Henri Begleiter, Floyd E. Bloom, Sheila B. Blume, Thomas E. Bryant, Leon Eisenberg, Dora Goldstein, Samuel Guze, David C. Lewis, Ting-Kai Li, Ruth Little, Herbert Pardes, Julius Richmond, Marc A. Schuckit, Robert Straus, Boris Tabakoff, and Phillip Zeidenberg.

The three publications which will result from the Research Conference are a conference report, a comprehensive review of the literature, and a consensus statement by the conferees citing the need for additional research on this high-risk population.

The *Report of the Conference on Research Needs and Opportunities for Children of Alcoholics* and the consensus statement prepared for the Conference are available from the Children of Alcoholics Foundation, 540 Madison Ave, 23rd fl, New York, NY 10022. *Children of Alcoholics: A Review of the Literature* will be available in 1985.

Irene R. Bush
Director
Children of Alcoholics Foundation, Inc
New York, NY

The Journal

Services for readers

In addition to regular news and opinion columns The Journal offers several special services to its readers.

Letters to the Editor are invited on any topic in the field and need not be restricted to comment on a recent article. Through the letter's column we offer readers an opportunity to discuss related issues, to "sound off," or to discuss new developments in their area.

All letters bearing the full name and address of the sender will be considered for publication.

Publishers are invited to forward advance copies of books for inclusion in the New Books column which appears on page 14. This column is designed to alert readers to new publications in the addictions and related fields and gives a synopsis of content as well as the purpose or rationale for the book.

Films, filmstrips, and videos are reviewed by a panel of experts at the Addiction Research Foundation. A synopsis of the subject matter of the projection, as well as comments, ratings, and recommended uses, are published regularly in The Journal's Projections column on page 13. The column is aimed at helping educators and treatment workers select materials best suited for their target audiences.

The Coming Events column on page 15 is a free service. A round-up of many of the conferences, workshops, and training events happening in upcoming months in Canada, the United States, and abroad, this column covers a broad spectrum of topics, locales, and target groups.

While all notices are considered, publication cannot be guaranteed. Those conference organizers, course planners, and treatment facilities wishing to ensure their message reaches readers of The Journal are invited to contact advertising coordinator, Judith Honey, Information and Promotion, 33 Russell St, Toronto, Canada M5S 2S1 for information on paid advertising space.

False trails hindering road to discovery

By Harvey McConnell

SANTA FE, N Mex — Research into finding traits or markers which can identify early in life those with an above-average susceptibility to compulsive drinking is a burgeoning facet of the alcoholism research field.

The depth of research in North America and Western Europe was highlighted by the number of reports presented here at the 2nd Congress of the International Society for Biomedical Research on Alcoholism.

Evident, as well, is that there will be many confusing signals and possible false trails before definitive markers and/or traits will be found to the satisfaction of the majority of scientists.

> **People don't realize science moves slowly, and this research is incredibly hard to do**
>
> **Schuckit**

Two leading researchers, and speakers, at the conference were Marc Schuckit, MD, Veterans Administration Medical Center, San Diego, and Donald Goodwin, MD, chairman of the department of psychiatry, University of Kansas, Kansas City. Both illustrated the problems they have found and commented to **The Journal**.

Dr Schuckit said it is important for anyone interested in the subject to understand the differences between state markers and trait markers.

As he defines it, a marker is an observable, usually easily-measured value which is linked to another problem somehow, "and you are trying to infer from the first easily-observable marker and its characteristics something about the second problem or factor."

State markers are seen only during the state of the illness, "and alcoholism is loaded with them, because alcohol affects so many systems profoundly." State markers can be helpful, as well, in diagnosis and observing remission.

Trait markers are vulnerability markers. "They are associated, or linked, to the disorder and factors which can be seen before the person gets ill, and which are likely to be seen, or to stay, when they become well," Dr Schuckit said.

Another issue is the attempt to see if the marker might be genetically influenced. "If you really get lucky, a marker may tell you something not only about the genetic flow, but it may also be a marker which is genetically related to why the person becomes an alcoholic."

There can be no perfect study in this area of research, and one must guard against any over-interpretation of research results. For example, there can be huge individual variations among the possible markers.

> **The dream I see . . . is that in 10 or 15 years the treatment and prevention of alcoholism will be different**
>
> **Schuckit**

Trait marker research is difficult to do; it is also slow, time consuming, and requires a lot of controls.

Dr Schuckit added: "Ten years ago most people would not have agreed it was probable there was a genetic influence on alcoholism. Now, we are starting to focus in on the situation that while not all the data is consistent, alcoholism is probably genetically influenced, and it is time to start looking at potential trait markers and vulnerability to alcoholism."

Some of his present studies with colleagues are among young men with a first-degree relative who is an alcoholic (family history positive) matched with young men without a biological first-degree relative who is alcoholic (family history negative). They are trying to see if there is a biological difference between the two groups which can be reproduced in some way.

They question about 1,200 college men each year, whittle out those with prior medical or psychological problems, and choose a number in both family history positive and family history negative groups, aged between 21 and 25 years who are drinkers, but not considered alcoholic, and who have no major problems.

The two groups are matched with a number of measures including weight, age, sex, religion, and educational levels. They are given, in random order, at three different sittings, placebo, the ethanol equivalent of three or four drinks, or five or six drinks.

Dr Schuckit said that when the men are questioned how they feel, the subjects in the family negative group have reported a greater effect from the ethanol than the family positive group. This effect they have replicated.

Blood chemistry marker changes, as well, have been seen between the two groups, but the data are still preliminary, Dr Schuckit added. Prolactin, for example, goes up after drinking in both groups, but stays up higher, longer, in the family history negative group. This correlates with their subjective feelings.

The researchers' newest measure, from which they are yet unable to draw any real conclusions, is a measure of body sway. In this test, the men stand with feet together and hands at the side, and they are attached to an arrangement of harnesses and pulleys.

Indications are that at low-dose ethanol levels the family history negative group sways much more than the family history positive group, but at higher ethanol levels there is little difference between the two groups; both sway heavily.

> **Eventually factors will be found which are essential for alcoholism to develop . . . without it, or them, you won't be alcoholic**
>
> **Goodwin**

Dr Schuckit said they exclude women from the study because the variabilities caused by the menstrual cycle and the contraceptive pill are too much to handle.

He said a danger at the moment is over-interpretation of findings by many members of the public because "people think of genetics as causative in psychiatric behavioral disorders, and in most medical disorders that are genetically related, you are not talking cause. You are talking contribution and vulnerability.

"People can over-interpret this by thinking that when one finds a potential trait marker this is causing alcoholism and all they have to do is go to a doctor and get tested. They don't realize science moves slowly, and this research is incredibly hard to do."

While he considers alcoholism is a biologically influenced, or contributed to, disorder, nothing which has been discovered so far should be used in clinical practice. He says this is asking too much after such a short period of funded research: less than 10 years.

While there is no specific treatment for alcoholism, "once we start understanding how these people (alcoholics) are different, maybe we can start to devise treatment programs which make much more sense with their needs."

Most talk of prevention of alcoholism is equated with education. "I don't know how to prevent alcoholism, and I am not sure education works, although this is all I have available to use. Maybe when we understand why some people are more vulnerable than others, then, perhaps, we can start prevention.

"The dream I see is that maybe in 10 or 15 years the treatment and prevention of alcoholism won't look at all like what we are doing today. It will be different, and different because of this basic kind of research."

Goodwin

Dr Goodwin pointed out that people can inherit characteristics which can cancel each other out. Feeling sick, for example, is probably as innate as anything. How sick can a person be and still function?

"You could have a person who has a high susceptibility to compulsive drinking, but a low susceptibility to tolerating illness. Both are traits which are inherited, but they produce a trade-off.

"This person could drink so little because he suffers so much from the effects of drinking."

In the case of alcoholism, as with infectious disease, Dr Goodwin continued, "you have to talk about the agent, the host, and the environment. People can become infected by the agent without becoming ill, but you will never be ill unless you are infected.

"I think you will find, eventually, factors which are essential for alcoholism to develop, and without it, or them, you won't become alcoholic. You know you have to have essential factors, and I think they are going to be measurable and isolated."

There will be other things playing a part along with the essential factors, such as availability of alcohol, or particular personality traits. They are not necessary factors for alcoholism, but may either amplify, or dampen, the essential process.

Dr Goodwin: "With all of this information, you will probably be able to predict with 80% to 90% accuracy — you will probably never improve on that figure —whether a person can become an alcoholic.

"I think the underlying process which makes alcoholism likely is, to some extent, a genetically determined dysfunctional state which requires the ingestion of alcohol to produce. I think also that some day there will be identified a chemical reaction to alcohol which sets up such a powerful need for alcohol that the choice of some people to drink normally is reduced to almost zero, regardless of what are the other countervailing factors.

"Some day we will find a marker which shows, if the person drinks, that the chances are 90% he will have no choice between compulsive drinking or avoiding alcohol. For these people there is no middle ground. Among the people we call alcoholics are those for whom I think this is true, and there will be a marker found for this, and it will be identifiable before the drinking starts

"There will also be a large group of excessive drinkers who may not be identifiable because the combination of factors that go into their drinking is more complex.

> **A large group of excessive drinkers may not be identifiable because the combination of factors is more complex**
>
> **Goodwin**

Schuckit

Dr Goodwin thinks most members of the public are unaware that children of alcoholics may run a greater risk of becoming problem drinkers in later life. Among those who do know of such a possible risk, many may believe the available evidence does not suggest that high a risk.

"If somebody thinks the risk is only one out of four or five, then they are not likely to change behavior that much. But if you can find something which can predict four out of five in a group may be at risk, then I think you can change behavior. Thus, the cost of research into markers is certainly justified."

Dr Goodwin said some of his latest research with Danish colleagues was among 134 sons of alcoholics and 70 sons of non-alcoholics, aged 19 to 21, and all of whom were part of a perinatal study carried out in Denmark 19 years previously (**The Journal**, April 1983).

One finding illustrates the difficulties in marker research.

Dr Goodwin said the young men were comparatively easy to approach because they had been involved in the perinatal study. No mention was made to them about their drinking habits, although the questions included some about drinking.

Both groups were given a battery of tests covering a number of items, including intelligence, memory, and attention. All of the values for all of the tests fell within the normal range in both groups.

Among the 50 tests, there were three where there were significant differences between the groups. But this ratio, three among 50, one would expect by chance.

However, Dr Goodwin continued, one of the three differences is fascinating: the sons of alcoholics consistently showed a deficit, albeit within the normal range, in the Halstead Categories test which measures abstract thought and concept formation. Over the years when alcoholics are given the categories test, they show a deficit.

Dr Goodwin added: "The fact that out of 50 measures you could have three significant differences between the sons of alcoholics and the sons of non-alcoholics, and the alcohol consumption among both groups is the same as far as we can tell, and one of the differences is the categories test, conceivably is not an accidental finding.

"It opens the possibility that the failure of alcoholics to do well on the categories test does not represent a consequence of heavy drinking, which has always been the interpretation, but actually may be the antecedent to heavy drinking.

"It is an interesting finding. But also, possibly, a chance finding."

NEWS

Myriad illnesses alert MDs to familial alcohol problems

By Tim Padmore

VANCOUVER — The first clue to a diagnosis of alcoholism often presents itself before the patient comes to the doctor's office.

The spouse or child of an alcoholic will often come to the family doctor with a condition that is largely the result of an alcoholic at home, doctors at the 26th scientific assembly of the College of Family Physicians were told here.

Elmer Ratzlaff, a Vancouver family physician who is also chairman for western Canada of the American Medical Society on Alcoholism, speaking at a plenary session of the meeting, said: "Spouses of alcoholics are often nervous, upset, and likely to request tranquillizers or sedatives for themselves. Symptoms may be vague and respond poorly to treatment.

"If we make a habit of searching beyond the identified patient for clues to illness and puzzling behavior, a casual mention that a spouse or father drinks a lot may take on diagnostic significance."

He said spouses and children may cover up for their alcoholic family member and "present a deceptively normal exterior to the world."

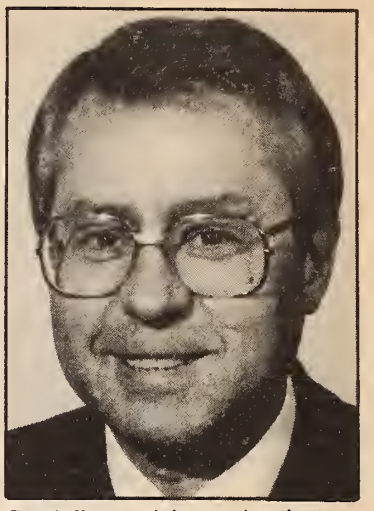
Complaints resulting from the other person's alcoholism may include insomnia, fear, anxiety, depression, sexual problems, and cardiac and gastro-intestinal problems.

Spouses of alcoholics feel a need to control and manage and blame themselves for problems.

Children may become anti-social or delinquent and go, or get sent, to the doctor for vague complaints.

Even the alcoholic patient is unlikely to complain about his or her alcoholism, Dr Ratzlaff said, so the physician has to be sensitive to "unspoken complaints."

Dr Ratzlaff, who began his presentation with a brief description of his own struggle with alcoholism, said early diagnosis not only benefits the patient, but also protects the doctor against the possibility of malpractice suits caused by error in diagnosis.



Ratzlaff: search beyond patient

EAPs broaden approach in face of health spending cuts

By Betty Lou Lee

HAMILTON — Higher health costs and government curtailment of health spending are encouraging wider community involvement in employee assistance programs (EAPs) and a "broad brush" orientation for them.

Ponée

Charles E. Ponée, EAP coordinator for the Eastern Ontario Region of the Addiction Research Foundation, Ottawa, told the 25th Institute on Addiction Studies here: "Health costs are up, services are on hold, so managers in the health field are looking more to prevention,'nipping things in the bud,' as less costly, and they see EAPs as early prevention.

"District Health Councils see their value, and are encouraging health units to support them," he told **The Journal**.

He cited a Cornwall consortium, as one example of community involvement, where 13 medium-sized companies pay $3 a year per employee to fund half the cost of a social worker at Cornwall General Hospital to help service their EAPs. The hospital pays the other half.

Citizen action groups which identify employee groups at high risk for alcohol and drug problems are another aspect of community involvement, Mr Ponée said.

Municipal government was identified as one such population in eastern Ontario, so a model EAP was set up for the regional municipality of Ottawa-Carleton, and other municipalities will be invited to learn about it early next year.

But it isn't only community endorsement that has widened the scope of EAPs, Mr Ponée said.

"To make them fully acceptable and financially feasible, many decided to enlarge them with a format that worked for one problem (addictions).

"We are all growing up — labor and organizations. We are all human, and we all have problems, and an EAP can help with the whole range of life's difficulties," he said.

While alcohol problems predominate in some work sites such as mining, they make up only 15% to 25% of overall referrals to EAPs, Mr Ponée said.

Law Reform Commission favors DWI blood sampling

TORONTO — It should be legal to take blood samples from unconscious drivers suspected of being impaired, says the Law Reform Commission of Canada.

However, the sampling should be done by professionally-trained individuals. The Commission also recommends that anyone taking the blood sample should also first obtain a judicial warrant and receive approval from the attending physician.

"The taking of a blood specimen is a safe and virtually painless procedure, and the direct analysis of a blood sample is the most accurate means of determining blood-alcohol concentration," the Commission says in a working paper entitled *Investigative Tests*.

The Commission acknowledges that such testing may be seen as contravening the Canadian Charter of Rights. However, it believes the taking of blood would constitute one of the "reasonable limits" that "can be demonstrably justified in a free and democratic society."

The working paper notes that some drivers will feign unconsciousness as a way of avoiding a breath test. Blood tests solve that problem and provide an accurate record of a person's level of impairment.

The Commission says there are arguments against blood testing but "considering the enormity of the problem caused by drinking drivers and, in particular, chronic offenders in this country, we don't find them convincing."

The Commission also believes the law should not permit taking blood samples from anyone who is conscious unless the person gives consent. Such a blood sample would be needed if the person is suspected of being impaired by drugs other than alcohol, the working paper states.

But, blood sampling shouldn't be done if a person has been hospitalized or is undergoing medical emergency treatment, the Commission adds.

It's also important to ensure there is no infringement of physicians' rights, the Commission says. If any investigative tests such as blood sampling are done a physician must give consent first.

The working paper notes that in some countries physicians are compelled to do the tests as a matter of course or when requested by a law enforcement officer who is investigating an impaired driving incident.

However, "it is our opinion that the conscription of physicians into the area of criminal investigation and law enforcement would constitute both an unjustified infringement of the individual rights of private physicians, and, in some instances, an unconscionable intrusion into the special relationship of doctor and patient," the paper states.

The working paper presents tentative views of the Commission. The police, defence, prosecution, and the judiciary have already made comments that will be considered in the final report.

That report will also take public comments into account and be presented in the future to the justice minister and Parliament.

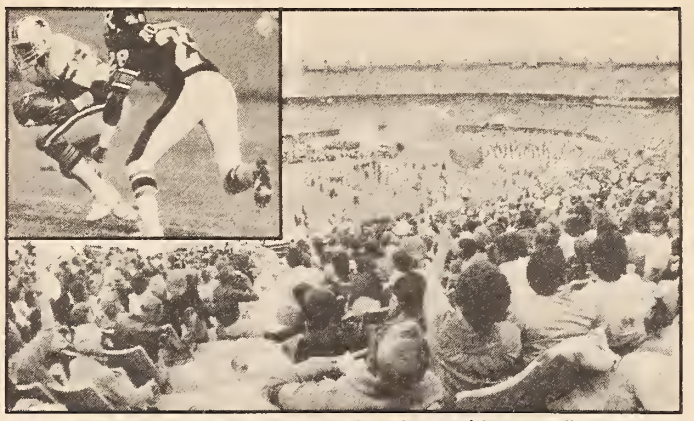
Stadium gets non-drinking seats

VANCOUVER — A temperance zone has been established for home games of the BC Lions football team.

One section of the 60,000-seat BC Place domed stadium has been set aside for non-drinkers.

In the remaining 58,800 seats, spectators are still free to drink beer purchased at stadium concessions.

Tickets for seats in the non-drinking section have "no alcohol" printed on the bottom and the stadium has posted signs in the passageways leading to the seats reading: "This is a non-drinking section. No alcohol beyond this point." Ushers are posted to intercept spectators bringing beer into the section.



BC Lions fans: temperance zone aimed at curbing rowdiness

The no-drinking section was set up according to an agreement in May between the football club and BC Place officials on a number of measures to curb rowdiness at football games.

Consumption patterns differ vastly

Drinking problems ignored, denied in SE Asia

By Lachlan MacQuarrie

HONG KONG — South East Asian countries have vastly different patterns of alcohol use and abuse; in many, there is a curious tendency to ignore, or even deny, the existence of associated problems.

This is the view of Pierre Stolz, former executive director of the Australian Foundation on Alcoholism and Drug Dependence, following a study of alcohol abuse patterns in the region.

He said the task was "mammoth and daunting" because of the large number of countries, the many different languages, and the lack of uniformity in data. His study included Japan, Hong Kong, the Philippines, Malaysia, Singapore, Papua New Guinea, Australia, and New Zealand. Findings were based on information obtained during a World Health Organization (WHO) study on alcohol-related problems in the employment setting.

• In Japan, 92% of adults believe alcohol is necessary in one's life, Mr Stolz said, and the annual per capita consumption of pure alcohol is about 5.7 litres. Only 15% of males compared to 55% of females never drink. In a population of 110 million, an estimated 1.7 million people consume 150 millilitres of pure alcohol or more a day.

An alcoholic is treated as a mental health patient in one of the 73 rehabilitation centres in Japan. Alcohol problems are not seen as public health problems and, said Mr Stolz, this runs counter to the need for early intervention and prevention.

• In Hong Kong, the officially-held view that alcohol abuse is not a problem is only now beginning to be questioned (**The Journal**, Feb). Though there is an absence of reliable information, there are signs of emerging problems. In a recent study of industrial accident victims, 43% had alcohol in their blood, although only 8% admitted to having consumed alcoholic beverages.

• The Philippines also has few data though drinking is acknowledged as a widespread practice. In rural areas, native wine is common, while beer is popular among urban Filipinos. Beer, brandy, whisky, rum, and vodka are all produced in the Philippines.

A recent survey of drinking habits among secondary school students indicated students begin to drink at about age 15, that 53% will drink on occasion, and that 6% drink daily. Yet, the Philippines does not have any program to deal with alcoholics, Mr Stolz told the 2nd Pan Pacific Conference on Drugs and Alcohol, here.

• Malaysia, he said, is another Asian country where little has been written about alcohol use and abuse, perhaps because of the built-in control systems of some of the constituent ethnic groups. The Islamic religion imposes strict sanctions on the Malay portion of the population and, although members of the Chinese community drink frequently, drunkenness among the Chinese is frowned upon.

In a recent study of alcoholic psychosis in Malaysia, 70% of all cases found were Indians (20% Chinese, 8.8% Europeans, 1.2% Malays) who are said to use alcohol frequently to relieve stress and anxiety. The Malaysian authorities do not see alcohol as a problem, Mr Stolz said.

• Similarly in Singapore, which has the same ethnic components as Malaysia, alcohol abuse is not seen as a problem. In a 1976 study, only 10 cases of alcoholic cirrhosis were detected in a population of 2.2 million. Where there does appear to be a problem, however small, is in the area of road trauma. Alcohol-related traffic deaths in 1978 amounted to 9% of all traffic deaths.

• In Papua New Guinea, indigenous drinks made from fermented fruit or coconut have given way to domestically-produced beer which, said Mr Stolz, has become a prestige commodity. Drinking has ceremonial characteristics in

Papua New Guinea and much of it takes place at feasts or other special occasions. Solitary drinking is rare and regarded as anti-social. Despite the fact that many of the drinking parties may result in brawls and rowdiness, Mr Stolz said, lawlessness and violence have not been seen, and alcohol has not become a major social problem (**The Journal**, May 1982).

• Australia, said Mr Stolz, "has the distinction of being the heaviest drinking, English-speaking country in the world." The per capita consumption of pure alcohol has remained steady at around 9.8 litres since 1974, and beer represents about two-thirds of all alcohol consumed. Recent studies indicate alcohol abuse in Australia is responsible for at least 15% of general hospital admissions and 50% of all traffic deaths, and represents a serious factor in criminal behavior, family discord, incest, and child abuse.

Mr Stolz commented that though there is an overall desire to reduce alcohol consumption in Australia, there has not been any national strategy to achieve this objective.

• The consumption of alcohol in New Zealand has increased steadily in the past 20 years and, in 1982, the consumption of pure alcohol per person more than 14 years of age was 12.1 litres. Beer represents 56% of all alcohol consumed.

Also, in the past 20 years, deaths from alcoholic liver cirrhosis in New Zealand have increased 263% to 34.5 from 9.5 per one million population. Alcohol is a factor in about 7% of general hospital admissions and, during 1982, more than 4,000 new cases were referred to 14 alcohol and drug centres throughout the country of about 3.25 million.

Mr Stolz said social costs of alcohol in New Zealand are similar to those in Australia. The establishment of an Alcoholic Liquor Advisory Council funded through a tax levy on alcoholic beverages is beginning to result in more effective primary prevention programs, including participation by the liquor industry in public relations campaigns aimed at drinking in moderation (**The Journal**, May).

In spite of the absence of uniform data, said Mr Stolz, some observations can be made.

"There is a curious lack of awareness of alcohol abuse problems and of their management in many of the countries where alcohol has been introduced as a result of Western influence," Mr Stolz said.

He recommended that the WHO support the collection of common data according to agreed indices so there can be comparable monitoring of per capita consumption, drinking patterns, and drinking problems.

Ireland lacking programs to educate teen drinkers

By Betty Lou Lee

HAMILTON — A physician active in employee assistance and community programs to prevent alcohol abuse in Ireland says North Americans have "a greater awareness of the problems facing kids" than his own countrymen.

William C.P. O'Flynn, medical director for employee health with Northern Telecom (Ireland) Ltd, Galway, says children 14 to 16 years have no trouble obtaining alcohol.

Parents believe it's up to priests or teachers to educate youth about alcohol, but most teachers don't consider themselves qualified because they have had no training, he said.

Dr O'Flynn attended the 25th annual Institute on Addiction Studies held here by Alcohol and Drug Concerns, Inc partly to learn about programs used in Canadian schools.

In his own community, an alcohol and drug advisory council has been formed among the police, schools, and health and social agencies. "There's a willingness and awareness, but they don't know what to do, especially the schools."

He's also been involved in setting up parent groups outside the schools, showing them how to build self-esteem in their children, so they can combat peer pressure.

Dr O'Flynn said a number of people have been pressuring government for proof-of-age identification cards, and to change legislation that says a seller must *knowingly* serve someone under 18 before he can be convicted of selling to a minor.

"There's a peculiar attitude to alcoholism: 'He's all right, he just takes too many,' " said Dr O' Flynn.

Even when someone is ready for help, there are relatively few services to which he or she can be referred. If hospitalization is required, it's usually in a psychiatric hospital, and the stigma attached to them impedes acceptance of treatment, he said.

A growth in microchip and small parts industries has also meant women are "slowly catching up to men" in alcohol abuse, since young women can make £100 to £150 (Cdn $175 to $262) a week.

Dr O'Flynn noted that 50% of the Irish don't drink at all. "But the other 50% drink enough to make up for them."

NEWS

Drunk drivers to be tutored about alcohol hazards

By Maureen Brosnahan

WINNIPEG — Beginning this fall in Manitoba, people charged with driving while impaired will be required to take a day-long education course before they can get their driver's licence back after suspension.

The program, announced recently by Manitoba Health Minister Larry Desjardins, and sponsored by the Alcoholism Foundation of Manitoba (AFM), is known as the First Offenders Program. It will provide general information on the hazards of drinking and driving and will emphasize the effects of alcohol on people and what the 0.08% blood-alcohol legal limit means.

"The general intent of the First Offenders Program is to make people aware of the problem," said Ross Ramsay, executive director of the AFM.

Mr Ramsay said the program will be started in the larger centres in Manitoba first, and then move into the smaller communities during the next three years. He said he expects 1,500 people to take the First Offenders Program between September 1984 and March 1985 and another 2,500 in the following 12 months.

The province has also decided to expand the Second Offenders Program throughout all of Manitoba beginning this fall. That program, which has been operating for the past year, is mandatory for all those who want to get their licences back after being charged and convicted of driving while impaired for a second time.

Mr Ramsay said Manitoba is the first province in Canada to offer special programs for both first and second offenders. He said some provinces do offer general courses for those convicted of impaired driving.

Mr Ramsay said the Second Offenders Program is designed not only to educate the impaired driver, but to rehabilitate and assess whether he or she may have a serious drinking problem.

"The probability of getting caught a second time is very rare. The suspicion is that there is something else going on," Mr Ramsay said.

Health department officials in Manitoba say that of those convicted of impaired driving, 30% are alcoholics. They say alcoholics make up 20% of first offenders, 50% of second offenders, and 90% of those charged a third time.

The estimated cost of the new First Offenders Program and the expansion of the Second Offenders Program is $467,000, Mr Desjardins said. He said the cost will be recovered from the impaired drivers who will be charged $125 each for the course.

Mr Ramsay said he supports the idea of charging impaired drivers the full cost of the course. "I'm pleased to see that those people who have done what they've done are paying for it themselves," he said.

This publication is indexed in

BIHEP

BIBLIOGRAPHIC INDEX OF HEALTH EDUCATION PERIODICALS

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000 ext 7384.

Kevin's Story

Number: 616.
Subject heading: Youth and alcohol, impaired driving.
Details: 19 min, color, 16 mm.
Synopsis: Kevin is an 18 year old who killed a girl when he was driving while intoxicated. He is sentenced to visit high schools to warn young people of the dangers of alcohol and, in particular, drinking and driving. In a high school auditorium Kevin recounts the events that led up to his accident: drinking before going to a party and drinking so heavily at the party that his friends tried to persuade him not to drive home. Following the accident, he did not want to face his parents at the police station, and his friends at school. He implores his listeners to examine their own drinking behavior and to try to quit drinking for one month.
General evaluation: Fair (3.1). Although Kevin's presentation was very emotional and dealt with many good points concerning drinking and driving, the film was somewhat limited by its lecture format. Furthermore, some messages seemed to be contradictory; eg, Kevin claimed he was making the presentations because he cared but, in fact, it was a sentence for his crime; he said he did not want his audiences' pity, yet he seemed to evoke their pity.
Recommended use: With a resource person this film could benefit high school students.

Drinking and Smoking: No Body Needs Them

Number: 617A.
Subject heading: Alcohol/alcoholism.
Details: 10 min, filmstrip, cassette.
Synopsis: This cartoon filmstrip is one of a two-part package (see Projection No 617B below). Good health is depicted as an equilateral triangle with physical health, mental health, and social health forming its sides. Alcohol use interferes with physical health which in turn affects mental and social health. The filmstrip illustrates stages of intoxication and their effects on reasoning.
General evaluation: Poor (2.1). The filmstrip's vocabulary was too sophisticated for the visuals. Although the filmstrip was made in 1982 it was taken from a much older 16 mm film, which accounted for the dated appearance of the filmstrip.
Recommended use: With a resource person, it could be used with audiences aged 12 to 15 years.

Drinking and Smoking: No Body Needs Them

Number: 617B.
Subject heading: Smoking.
Details: 10 min, filmstrip, audio cassette.
Synopsis: (See Projection No 617A above). Edgar has a job as sports director for a dude ranch. He always seems to be ignored by the guests, and no one respects him. He decides to see if smoking will help him gain some respect. However, that night he dreams about being a judge at a trial. On trial is the issue of smoking. His boss, Ms Hackwell, presents the case for smoking, while a guest presents the other side. Edgar decides not to smoke and wins a marathon race, while the smokers fall by the wayside.
General evaluation: Poor to fair (2.7). This filmstrip seemed dated and of poor technical quality.
Recommended use: With a resource person, it could be used with audiences aged 8 to 11 years.

Turning off: Drugs and Peer Pressure

Number: 618.
Subject heading: Attitudes and values, drugs and youth.
Details: 20 min, two filmstrips, audio cassette, 20 min.
Synopsis: Young people are subjected to many influences to use drugs. Some of these influences are subtle, and it is important that they be recognized, in order that they may be dealt with. Measures to counteract the more overt influences are illustrated, eg "broken record," "fogging," and "end of discussion." Everyone should be able to make up his or her own mind with sufficient confidence to resist pressure from peers and other sources.
General evaluation: Good to very good (4.9). This contemporary filmstrip showed how influences can work, and good ways to counteract them. It was judged a good teaching aid.
Recommended use: With a resource person to facilitate the suggested role playing, this filmstrip could benefit audiences 11 to 18 years.

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DEPARTMENT

New Books by RON HALL

Adolescent Drug Abuse: Intervention Strategies

. . . edited by Thomas J. Glynn, Carl G. Leukefeld, and Jacqueline P. Ludford

The material in this volume comprises the United States National Institute on Drug Abuse's Research Monograph No 47. The role of mass media campaigns in drug abuse prevention is discussed and the importance of media in the lives of children is emphasized. General and specific influences on health behavior from the perspective of societal influences, family, peers, school, and individual psychology are discussed and categorized. Prevention is approached from the standpoint of four domains of health: physical, psychological, social, and personal. Several community prevention projects are described, evaluated, and discussed. Research is presented that involves a prevention strategy focused on the enhancement of personal competence through basic lifeskills training and the acquisition of problem-solving skills and resistance skills. The research on alternative programming as a prevention strategy and research with school/parent groups and their effectiveness are presented. Social skills training for adolescents as a possible approach to preventing drug abuse is addressed as a topic. A final chapter is devoted to a summary.

(National Institute on Drug Abuse, Room 10-A-43, 5600 Fishers Ln, Rockville, MD 20857, 1983. 261 p.)

Drug Abuse: Foundation for a Psychosocial Approach

. . . edited by Seymour Eiseman, Joseph A. Wingard, and George J. Huba

The purpose of this book is to offer a different approach to education about drug abuse. The editors have avoided the traditional model of substance physiology, metabolic function, and drug classification. As an alternative, the book focuses on theory, research, and practice pertaining to drug abuse using a psychological, rather than medical, perspective. The first part examines theoretical models proposed to address questions about education, school programs, and psychosocial factors affecting decisions to use or not to use drugs. Various reflections on the value of research and program development are discussed. The second part presents selected research studies describing the attitudes of elementary and junior high school students toward cigarette smoking and the use of drugs. In addition, investigations about the awareness of substance abuse among preschool children is examined. Part three is devoted to an examination of reports of some practices employed in a variety of settings which may be contributing to or serving as deterrants to drug abuse.

(Baywood Publishing, 120 Marine St, Farmingdale, NY 11735, 1984. 268 p. $16.75. ISBN 0-89503-039-X)

Other books

National Drug Institute: Innovations — Carvolth, Russell (ed). Australian Foundation on Alcoholism and Drug Dependence, Canberra, 1983. Proceedings of the National Drug Institute in Brisbane, Australia, May 19 to 21, 1983; smoking cessation policy; drug information in the 1980s; Australian drinking patterns; convictions and rehabilitation; hoteliers and health workers; educating doctors in health-related problems of alcohol. 91 p. Australian Foundation on Alcoholism and Drug Dependence, PO Box 477, Canberra City, ACT 2601. ISBN 0-909190-18-6.

Addicted and Free . . . at the Same Time — Stewart, David A. Empathy Books, Toronto, 1984. "A study of addiction and fellowship;" meaning of addiction; psychological addict; disordered lover; broken habit; art of feeling bad; philosophy of fellowship; empathic person; the habit made whole; art of being free. 181 p. Empathy Books, 33 Orchard View Blvd., #316, Toronto, ON M4R 2E9. $12.95.

Social Work Treatment of Alcohol Problems — Cook, David; Fewell, Christine; and Riolo, John (eds). Rutgers Center of Alcohol Studies, New Brunswick, 1983. Alcoholism treatment resources; routine screening for alcoholism; how to conduct an alcoholism-focused intake interview; systematic family therapy and the treatment of intoxication; psychoanalytic contributions to alcoholism treatment; mental illness and alcoholism; day treatment; alcoholic women in treatment; adolescents; employee assistance programs in hospital settings. 153 p. Rutgers Center of Alcohol Studies, PO Box 969, New Brunswick, NJ 08854. $15. ISBN 911290-15-X.

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Royal College of Physicians and Surgeons of Canada: Annual Meeting — Sept 10-13, Montreal, Quebec. Information: Royal College of Physicians and Surgeons of Canada, 74 Stanley Ave, Ottawa, Ontario K1M 1P4.

University of Toronto Department of Psychiatry 10th Annual Research Day — Sept 21, Toronto, Ontario. Information: K. Drysdale, Secretary, Research Fund Committee, Clark Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Detox Training Programs (Nonmedical) — Sept 24-28, Oct 22-26, Nov 19-23, Toronto, Ontario. Information: Diane Hobbs, Coordinator of Detox and Rehabilitation Programs, Addiction Research Foundation (ARF), 33 Russell St, Toronto, ON M5S 2S1.

AADAC Mini-School 84: Children of Alcoholics: Beyond the Lingering Legacy — Sept 30-Oct 2, Calgary, Alberta. Information: Alberta Alcoholism and Drug Abuse Commission, 3rd fl, 1177-11th Ave, SW, Calgary, AB T2R 0G5.

Workplace 84 "Making the Most of Human Potential" An Employee Assistance Programming Conference — Oct 15-17, Grande Prairie, Alberta. Information: Iyas Abbas, Alberta Alcoholism and Drug Abuse Commission, Provincial Bldg, Rm 2204, 10320 99 St, Grande Prairie, AB T8V 6J4.

5th Annual Meeting Canadian Group Psychotherapy Association — Oct 17-20, Ottawa, Ontario. Information: Edgardo Perez, MD, department of Psychiatry, Civic Parkdale Clinic, 3rd fl, Ottawa Civic Hospital, 737 Parkdale Ave, Ottawa, ON K1Y 4E9.

22nd Annual Scientific and Business Meeting, Ontario Chapter College of Family Physicians of Canada — Oct 17-20, Toronto, Ontario. Information: Lyn Robinson, Chairman, 1984 Convention Committee, 4000 Leslie St, Willowdale, ON M2K 2R9.

Addiction Awareness Week — Oct 21-28, Toronto, Ontario, and other communities. Information: Joe Taylor, Director of Vincent Paul Community Houses, 240 Church St, Toronto, ON M5B 1Z2, or Mary Pakula, ARF, 175 College St, Toronto, ON M5T 1P8.

Event 84 Skills Development Training Programs for Employee Assistance Personnel — Oct 28-Nov 1, Oakville, Ontario. Information: James Simon and Jaan Schaer, United Employee Assistance Councils of Ontario, Port Credit, Box 253, Mississauga, ON L5G 4L8.

Intervention Workshop — Someone I Care About is Abusing Chemicals — Oct 31, Nov 28, Jan 23, 1985, Toronto, Ontario. Information: Yvonne Johns, department head, Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Community Development Workshop — Nov 5, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Anxiety Disorders: Theory, Diagnosis and Treatment — Nov 8-9, Toronto, Ontario. Information: Evon Essue, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Drinking and Driving — Together We Can Beat It — Nov 22-23, Winnipeg, Manitoba. Information: Project Prevention, bldg 3, 2nd fl, 139 Tuxedo Ave, Winnipeg, MB R3N 0H6.

Scientific Meeting on Sexually Transmitted Diseases — Nov 26-27, Vancouver, British Columbia. Information: Ruth Sutherland, Chairman, Program Committee, STD Division, Canadian Public Health Association, 1335 Carling Ave, Ste 210, Ottawa, Ontario, K1Z 8N8.

Perspectives on Employee Assistance Programming Course — Nov 26-29, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Chemical Abuse and Your Employee — Nov 28, Jan 23, 1985, Toronto, Ontario. Information: Yvonne Johns, department head, Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Group Therapy Course — Jan 14-18, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Ontario Psychiatric Association Annual Meeting — Jan 24-26, 1985, Toronto, Ontario. Information: Frank E. Cashman, Program Committee Chairman, or Jean Reed, Executive Secretary of the Ontario Psychiatric Association, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Health Promotion Workshop —Feb 13-15, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

What Every Employer Needs to Know — Feb 20-22, 1985, Toronto, Ontario. Information: Yvonne Johns, department head, Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Behavioral Interventions Course — March 27-29, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Relaxation and Stress Management Course — April 15-16, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

National Conference on Autism — May 15-17, 1985, Winnipeg, Manitoba. Information: Manitoba Society for Autistic Children, 649 Bardal Bay, Winnipeg, MB R2G 0J1.

Parent Resources Institute for Drug Education (PRIDE-CANADA Inc) 1st Annual National Conference — May 30-June 1, 1985, Saskatoon, Saskatchewan. Information: Ruth Kell, Convenor, PRIDE-Canada, Ste 111, Thorvaldson Bldg, College of Pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-10, 1985, Calgary, Alberta. Information: Jan Skirrow, Chairman, 34th ICAA Congress, AADAC, 6th fl, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

United States

Family and Child Sexuality — Sept 10-11, Minneapolis, Minnesota. Information: Diane Campbell, Program in Human Sexuality, 2630 University Ave SE, Minneapolis, MN 55414.

Training School on Alcohol and Drug Use — Sept 10-28, Minneapolis, Minnesota. Information: Seminar Coordinator, Johnson Institute, 10700 Olson Hwy, Minneapolis, MN 55441-6199.

Relational Issues of Addiction: Violence, Sexuality, and Intimacy — Sept 17-19, San Diego, California. Information: Naomi Feldman, Conference Coordinator, 3770 Tansy, San Diego, CA 92121.

Intervention Skill-Building — Sept 17-21, Minneapolis, Minnesota. Information: Seminar Coordinator, Johnson Institute, 10700 Olson Hwy, Minneapolis, MN 55441-6199.

Adolescents, Alcohol, and Drugs — Sept 20-21, Portland, Maine. Information: Seminar Coordinator, Johnson Institute, 10700 Olson Hwy, Minneapolis, MN 55441-6199.

3rd National Conference of National Federation of Parents for Drug-Free Youth — Sept 27-29, Washington, DC. Information: National Federation of Parents for Drug-Free Youth, 1820 Franwall Ave, Ste 16, Silver Spring, MD 20902.

1st Annual Sidney Cohen Lectureship — Sept 28, Beverly Hills, California. Information: Linda Derman, The Institute for Studies of Destructive Behaviors and the Suicide Prevention Center, 1041 South Menlo Ave, Los Angeles, CA 90006.

4th Annual Workshop on Marketing Mental Health Services and Employee Assistance Programs — Sept 30-Oct 2, Breckenridge, Colorado. Information: Laurie Loeb, Colorado West Regional Mental Health Center, PO Box 40, Glenwood Springs, CO 81602.

Alcoholism and Chemical Dependency: Family Focus — Sept 30-Oct 2, Bellaire, Michigan. Information: Sally Myers, MAAA, 21711 W Ten Mile Rd, Ste 105, Southfield, MI 48075.

Evaluating Employee Assistance Programs — Oct 1, Denver, Colorado. Information: Hazelden Foundation Continuing Education, Box 11, Center City, Minnesota 55012.

Current Concepts of Addictions Nursing — Oct 4, Chicago, Illinois, Nov 1, Orlando, Florida. Information: NNSA-Seminars, 2506 Gross Point Rd, Evanston, IL 60201.

Alcohol and Drug Problems Association (ADPA) Northwestern Regional Conference — Oct 7-9, Seattle, Washington. Information: Eric Scharf, ADPA, 1101 15th St, NW, #204, Washington, DC 20005.

36th Annual Convention and Scientific Assembly of American Academy of Family Physicians (AAFP) — Oct 9-12, Kansas City, Missouri. Information: The American Academy of Family Physicians, 1740 W 92nd St, Kansas City, MO 64114.

Evaluating Treatment Programs — Oct 10, San Francisco, California. Information: Hazelden Foundation Continuing Education, Box 11, Center City, Minnesota 55012.

American Medical Writers Association 44th Annual Conference — Oct 10-13, San Antonio, Texas. Information: American Medical Writers Association, 5272 River Rd, Ste 410, Bethesda, MD 20816.

American Association for Marriage and Family Therapy 42nd Annual Conference — Oct 18-21, San Francisco, California. Information: AAMFT Conference Committee, 1717 K St, NW, Ste 407, Washington, DC 20006.

1984 Postgraduate Course in Clinical Pharmacology, Drug Development, and Regulation — Oct 22-Oct 26, Rochester, New York. Information: Kristine Niven, Administrator, Center for the Study of Drug Development, The University of Rochester Medical Center, 601 Elmwood Ave, Rochester, NY 14642.

Counseling Skills Seminar — Oct 29-Nov 2, Minneapolis, Minnesota. Information: Seminar Coordinator, Johnson Institute, 510 1st Ave N, Minneapolis, MN 55403.

18th Annual Association for the Advancement of Behavior Therapy Convention — Nov 1-4, Philadelphia, Pennsylvania. Information: John E. Martin, PhD, Program Chairperson, AABT/84, Psychology (116B), VA Medical Center, Jackson, Mississippi 39216.

Current Clinical Psychopharmacology — Nov 2, New Hyde Park, New York. Information: Ann J. Boehme, Continuing Education Coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042.

Alcohol, Drugs, and the Family — Nov 5-9, Minneapolis, Minnesota. Information: Seminar Coordinator, Johnson Institute, 510 1st Ave N, Minneapolis, MN 55403.

Intervention Skill-Building — Nov 7-9, Houston, Texas. Information: Seminar Coordinator, Johnson Institute, 510 1st Ave N, Minneapolis, MN 55403.

4th Annual Fall Conference on Alcoholism — Nov 7-9, Williamsburg, Virginia. Information: Craig Nuckles, director, Riverside Hospital Alcoholism Treatment Program, J. Clyde Morris Blvd, Newport News, VA.

AMERSA (Association for Medical Education and Research in Substance Abuse) 8th Annual Conference — Nov 8-9, Washington, DC. Information: Conference coordinator, c/o David Lewis, MD, Brown University, Program in Medicine, Box G, Providence, RI 02912.

2nd National Conference on Alcohol and Drug Abuse Programming for Colleges and Universities — Nov 11-14, Boston, Massachusetts. Information: Eric Scharf, Alcohol and Drug Problems Association, 1101 15th St, NW, #204, Washington, DC 20005.

Alcoholism, Drug Dependence, and Family Recovery — Nov 12-16, Minneapolis, Minnesota. Information: Seminar Coordinator, Johnson Institute, 510 1st Ave N, Minneapolis, MN 55403.

Assessing and Treating Adolescents for Alcohol and Drug Abuse — Nov 15-17, Dallas, Texas. Information: Seminar Coordinator, Johnson Institute, 510 1st Ave N, Minneapolis, MN 55403.

9th Southeastern Conference on Alcohol and Drug Abuse — Nov 28-Dec 2, Atlanta, Georgia. Information: Barbara Turner, Charter Medical Corporation, Addictive Disease Division, 5780 Peachtree Dunwoody Rd, NE, Ste 170, Atlanta, GA 30342.

Abroad

23rd International Congress of Psychology — Sept 2-7, Acapulco, Mexico. Information: ICP Congress Coordinator, PO Box 32366, San Antonio, Texas 78216.

8th World Conference of Therapeutic Communities — Sept 2-7, Rome, Italy. Information: Charles J. Devlin, Executive Director, Daytop Village Inc, 54 W 40th St, New York, NY 10018.

Seminar on Addiction — Sept 6-14, Athens, Greece. Information: Darcy Edwards, Millglen Medical Corp, PO Box 888673, Atlanta, Georgia 30356-0673.

International Congress on Alcohol Dependence, the Family and the Community — Sept 16-22, Jerusalem, Israel. Information: International Congress on Alcohol Dependence, the Family and the Community, Kenness International Inc, 1 Park Ave, New York, NY 10017.

11th International Conference of Social Gerontology — Oct 16-19, Rome, Italy. Information: International Center of Social Gerontology, 91, rue Jouffroy, 75017 Paris, France.

The Association for Behavior Therapy: 14th Annual Meeting, Sept 17-19, Brussels, Belgium. Information: Secretariat, 14th Congress of EABT, Tiense Str 102, B-3000, Leuven, Belgium.

International Workshop on Punishment and/or Treatment for Driving under the Influence of Alcohol and other Drugs — Current Concepts and Prospectives — Pros and Cons —Oct 19-20, Stockholm, Sweden. Information: ICADTS, Box 5815, S-102 48 Stockholm, Sweden.

1984 World Congress of Acupuncture and Natural Medicines — Oct 19-24, Colombo, Sri Lanka. Information: Dr Anton Jayasuriya, Secretary-General, Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

"Addiction: A Hundred Years On" Centennial Symposium — Oct 25-26, London, England. Information: The Royal Society, 6 Carlton House Terrace, London SWI, England.

2nd Inter-American Symposium on Health Education — Nov 4-9, Acapulco, Mexico. Information: Symposium Steering Committee, c/o NARO, PO Box 2305, Station "D," Ottawa, Ontario, K1P 5K0.

Prophylactics of Drug Abuse — Dec 10-12, Warsaw, Poland. Information: Secretariat of the Symposium, Society for Prevention of Drug Abuse, Aleje Ujazdowskie 22, 00-478 Warsaw, Poland.

International Youth Forum on Alcohol and Drugs — July 9-12, 1985, Cardiff, Wales. Information: Dr Myrddin Evans, Addiction Unit, South Glamorgan Health Authority, Whitchurch Hospital, Whitchurch, Cardiff, CF4 7XB, United Kingdom.

2nd National Drug Institute ("Social Change and Drug Use Patterns") — Aug 14-16, 1985, Darwin, Northern Territory, Australia. Information: NDI Planning Committee, NT Drug and Alcohol Bureau, department of Health, GPO Box 1701, Darwin, NT 5794, Australia.

12th International Conference on Health Education — Sept 16, 1985, Dublin, Ireland. Information: Dr H.D. Crawley, Director, Health Education Bureau, 34 Upper Mount St, Dublin, Ireland.

UN health, food agencies clash

Tobacco: profit or loss for the hunger-belt

LONDON — The tobacco companies seem to be gaining ground in a widening public conflict between two of the United Nations' (UN) most powerful organizations and their supporters over the current, steep increase of cigarette manufacture and consumption around the hungry belt of the globe.

They are the Geneva-based World Health Organization (WHO), which is concerned with the medical and social costs of smoking, and the Rome-based Food and Agriculture Organization (FAO), which is reluctant to advise Third World farmers to forgo the short-term profits which they can earn from cultivating tobacco. The UN Industrial Development Organization (UNIDO), a much smaller although widely influential global agency based in Vienna, has now entered the controversy by adopting the FAO's pragmatic, short-term approach to tobacco profits.

The embarrassing policy split between the opposing camps in the UN "family" of organizations could affect profoundly the crucial process of development planning in public health and agriculture throughout the hungry world.

At best, the conflict of priorities between the two specialist agencies will cause confusion in many government departments which have come to rely on their authoritative advice as well as multilateral aid funds. At worst, it can lead to conflicting policies and wastage of resources on a gigantic scale in areas of development planning where routine decisions frequently affect the health and livelihood of huge populations.

The UNIDO was one of 10 UN agencies participating in secret discussions in 1981 seeking to resolve the conflict through compromise. The FAO and the World Bank grudgingly agreed then to reduce their considerable financial and other support to Third World tobacco growing projects. But a WHO participant disclosed afterwards that "frank discussions" at the meeting "revealed that there were considerable differences of approach to the problem by different organizations reflecting often very different constituencies, although it was recognized that smoking-related diseases cause major economic losses."

Attempts at disguising the split are now being abandoned. The WHO has just called on the governments of poor countries to curb the activities of the tobacco industry — which enjoys the support of the FAO.

Tobacco is grown in about 120 countries, many of them in the developing regions which have recently overtaken the rich world both in the production and in the consumption of cigarettes (**The Journal**, June 1983). Many poor countries have entered the tobacco business in a big way during the past decade or two in the hope of raising a foreign exchange income to finance economic development. But the bulk of the cigarettes produced in the Third World are also consumed there by a growing local market; and the WHO considers that the control and reversal of the now developing "smoking epidemic" there "could do more to improve health and prolong life . . . than any other single action in the whole field of preventative medicine."

Other major issues in the controversy concern the global environment and economy. One of every eight trees cut down is used as fuel for curing tobacco, according to a recent estimate, contributing to the rapid deforestation of the planet. In the long-term, this could lead to shifting rainfall patterns and permanent drought affecting the great breadbasket regions of the northern hemisphere.

Growing dilemma: 'The bulk of the cigarettes produced in the Third World are also consumed there.' Above, tobacco planting in Zimbabwe, flanked by smokers (clockwise from bottom left) in Brazil, the Transkei (South Africa), Malaysia, and China.

A study published by War on Want here in London concludes that developing countries have been unable to resist the spread of the tobacco business "because the companies offer a package deal which operates on every level — from teaching the farmer how to grow the crop, to capitalizing the processing plants, guaranteeing the market through brand names and advertising, and offering profit opportunities to the ruling families."

An analysis issued by the UN Conference on Trade and Development observes that "at all stages of the production and marketing chain, a handful of giant companies, whose epicentres of power remain the United States, South Africa, and Britain, exercises decisive control."

But the FAO offers a different assessment. The organization asserts, in a recent, closely argued study, that the tobacco industry creates many immediate and tangible social and economic benefits — especially in the poor countries.

It concludes that "tobacco growing generates large-scale rural employment in over-populated areas and provides a ready source of cash for smallholders who would otherwise be dependent on less remunerative crops or on subsistence farming. In nearly every producing country, tobacco is one of the most valuable crops grown, and its contribution to the total agricultural income is almost invariably significant, reaching 25% in the case of Zimbabwe.

"Tobacco is also one of the most remunerative cash crops, yielding net returns per unit of land which may be several times higher than those obtained from industrial crops or staple foodstuffs. In addition, tobacco leaf is an important source of foreign exchange for exporting countries, making a substantial contribution to the argicultural export earnings of many countries especially in Africa and Asia.

"Tobacco manufacturing also creates extensive opportunities for employment," the study says, "particularly in developing countries where manual methods of production are still the rule. The wages and salaries paid by tobacco factories compare favorably with those paid by other industries . . . World exports of tobacco products were valued at $3,500 million annually in 1979 to 1981 and, although only 6% of this total accrued to developing countries, some of them earned sizeable amounts of foreign exchange from this trade.

"Finally, tobacco products are a very important and easily tapped source of tax revenue for governments in both developing and developed countries . . . . In view of these factors, farmers continue to have strong incentives to produce tobacco and governments to encourage its cultivation and manufacture."

While the WHO fears an epidemic of smoking-related diseases sweeping the developing regions within a decade, the FAO is concerned with filling empty bellies today.

While every point raised in the tobacco controversy may be important and every statistic cited may be true, opponents have carefully refrained from answering each other's arguments. Governments and financial and political pressure groups in the hungry world are thus invited to take sides according to their perception of their immediate interests or, more likely, to suit the personal preferences of their leaders.

The tobacco lobby, therefore, seems to have gained the upper hand partly because short-term considerations tend to favor the industry and partly because personal preferences may well be influenced by the companies' recently-intensified, vigorous advertising campaigns in the Third World.

The climate of preferences among influential health professionals in the developing regions is illustrated by statistics published by the Royal College of Physicians here in London. While most British doctors have given up smoking, 72% of medical students in Lagos smoke, and so do 39% of doctors in Bangladesh.

And, the global trend may now be accelerated by the decision taken publicly by the UNIDO to promote the use of solar energy for tobacco curing in Asia. The project envisages the application of an "appropriate" technology for the exploitation of a renewable source of energy to protect the environment by saving scarce wood supplies while raising rural incomes to improve the quality of life in the villages.

It is a modest project in terms of effort, capital investment, energy generation, and indeed woodlands potentially saved. But it may do disproportionate damage globally to the WHO campaign to curb tobacco cultivation. For the project, every peripheral aspect of which seems to satisfy the objectives of the health and environment lobby, commits the authority of the UNIDO to the cause of the FAO and the tobacco industry by encouraging cigarette production in the developing regions.

By Thomas Land

THE BACK PAGE

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The Journal

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Government faces opposing recommendations

MDs clash in heroin as medicine debate

By Anne MacLennan and Betty Lou Lee

TORONTO — As Canada's new Progressive Conservative government settles into leadership, the future is uncertain for two strong but apparently conflicting recommendations to government on the use of heroin as medicine.

Federal drug bureaucrats, who've operated almost exclusively under the Liberal party for more than 20 years, are of one, no-predictions voice; what happens to the recommendations is up to government.

Appearing slightly less vulnerable to political winds, because now entrenched in the system, is another and separate Liberal government initiative from last year — clinical trials to compare pain relief from heroin and other narcotic drugs, such as morphine and Dilaudid (hydromorphone), in cancer patients.

The protocol is almost complete, and the trials should be ready to go by late autumn, Denys Cook, PhD, director-general of Health and Welfare's Drug Directorate, told **The Journal**. He says his office is proceeding on the assumption they'll be going ahead. They're expected to take about two years.

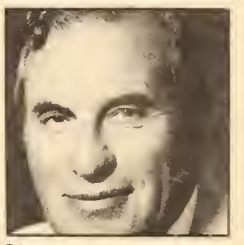
For now, government faces one recommendation from the 38,000-strong Canadian Medical Association (CMA) that calls for removal of the 30-year ban on prescribing heroin for "medicinal purposes."

In an annual meeting debate that had almost as much political as medical content, the vote wasn't even close enough to require a standing count, in spite of predictions it could go either way. This runs counter to the position of the American Medical Association, which, in a similar debate in the United States, (**The Journal,** May) has now said there is no medical need to reintroduce medical use of heroin.

Says Jacques LeCavalier, director of Canada's Bureau of Dangerous Drugs, what is commonly referred to here as the ban on heroin is specifically a ban on importation of heroin. It stems from a 1954 health ministry policy decision to disallow importation of heroin. All that's needed to change that, he says, is a new policy decision allowing issuance of permits to drug companies wishing to import and distribute the drug for medical purposes.)

Begin

Sellers



Ghent

The other recommendation to government, however, is that "heroin not be reintroduced in Canada at this time since information available does not support the need for this drug." This from the 10-member expert, and medical, advisory committee set up last year by then Health Minister Monique Begin to examine "the management of severe chronic pain in cancer patients."

The committee, headed by Edward Sellers, MD, director of the Addiction Research Foundation's Clinical Institute here, focused on three questions: Why is the optimal treatment of severe pain not achieved? What can be done to improve the management of severe pain? Would the availability of heroin have any impact on improving management of severe pain?

In its recently-released report, the committee concludes: ". . . deficient pain control experienced by cancer patients in Canada is not related to a need for heroin but to inadequate knowledge and prescribing practices concerning narcotic analgesics, and the existence of some pain syndromes which are not responsive to narcotic analgesics for which other therapeutic options must be developed."

In Britain, one of the chief manufacturers and users of heroin medically, "poor pain control still occurs," says the committee.

"Improvement in pain control will occur through the dissemination and application of current knowledge and treatment tactics and continuing research regarding management of problem cases.

"If heroin were available in Canada, the fundamental causes of inadequate pain control would not change. What must change is how we use the available agents."

Instead of heroin, the committee suggests in summary: "Marketing of a high-potency formulation of hydromorphone or morphine acetate would meet the limited need for a high-solubility, high-potency, injectable analgesic. Methadone is already available in Canada and may also be used."

Meanwhile, the report notes: "Whatever the causes of sub-optimal care, clinical experience and the medical literature are remarkably consistent in their judgement that treatment failures occur and that most such failures are preventable."

Their recommendations for improving care touch on medical, nursing, and para-medical personnel; the public, researchers, and health care services.

In the CMA debate, although a highly-publicized and emotional appeal for the use of heroin for terminal cancer patients has been made for the past two years by medical columnist Dr Kenneth Walker of Niagara Falls, Ont, there was relatively little mention of cancer patients.

There was more talk of how Parliament had been misled 30 years ago into thinking the CMA supported the ban; how heroin addiction, a medical condition, had been criminalized; and how doctors were being told by politicians how they can practice medicine.

Obviously delighted with the vote, William Ghent, professor of surgery at Queen's University, Kingston, Ont, predicted quick action by the new federal government. (See — Heroin — page 2)

PCP resurgence, cocaine tabs confounding US drug experts

By Harvey McConnell

WASHINGTON — A major resurgence of phencyclidine (PCP) use in several United States cities, and the appearance of cocaine-loaded gelatin tablets intended for young people, are two major worries of US drug abuse officials.

William Pollin, director of the US National Institute on Drug Abuse (NIDA), told the annual conference here of the Alcohol and Drug Problems Association of North America that Washington, Los Angeles, and New York are among the cities where PCP use is again rampant.

The majority of admissions in the past five months to St Elizabeth's, the federal mental hospital in the District of Columbia, have been because of acute psychotic episodes related to PCP use.

(The drug was found in 65 people who died traumatic deaths in 1983, District of Columbia officials have said, compared with 15 in 1982. Although known nation-wide as "angel dust," in Washington, PCP is called also "the key to St E's" and "Hinckley," because one of the patients at the hospital is John Hinckley, the man who shot President Reagan.)

There is no real explanation for such random outbreaks of drug use, Dr Pollin said. "We're not able to find any of the social or cultural factors that can explain in any conceptual way why these kinds of outbreaks with different drugs occur specifically. We know they do occur, and they will continue to occur."

Dr Pollin later noted that PCP, like inhalants, can give users "the biggest bang for the buck," and economic factors could play a part in the use of such drugs.

As for cocaine, he said, a most-disturbing factor is that "we are hearing of a new pattern of distribution of gelatin capsules filled with cocaine and selling for about $10 a capsule. There could be a whole new range of users in school age kids."

In some parts of the country, the price of cocaine has dropped to about $40 a gram.

Dr Pollin added: "We don't know at present if the continued increase in clinical problems associated with cocaine represents the predictable five-year-later consequences of the substantial dramatic peak of marijuana use in 1979 — 1980; or, whether it represents a breakthrough regarding prevalence into a really new expansion of cocaine use."

The idea that this is a predictable late stage sequence of peak marijuana use is consistent with studies which have shown the best single predictor of heavy cocaine use among people in their twenties is heavy, early marijuana use. Other studies have shown a five year gap between the first use of cocaine and the appearance of serious medical problems.

Children of alcohol: generation at risk

By Maureen Brosnahan

WINNIPEG — Children of alcoholics need to be identified and provided with early counselling because they run a high risk of becoming alcoholics themselves in later life, says a psychiatry professor at the University of Manitoba.

Nady el-Guebaly said numerous studies show that a child whose father was alcoholic has a four times greater risk of developing a drinking problem than a child of a non-alcoholic parent.

As well, children whose mothers are alcoholics are also at risk both physically and emotionally, he told the Issues in Chemical Dependency Conference here.

While cases of this are less frequent, "the impact is much more severe (on the children)," Dr el-Guebaly said.

He said in Manitoba alone there are more than 50,000 children at risk. These are the children of the estimated 5% to 10% of the population who are alcoholic in the province.

Dr el-Guebaly said such children need to be identified and offered counselling. "Kids of chemically dependent parents have a lot of problems. Kids of chemically dependent parents need a lot of help."

Although he said not every child would need intensive counselling, they all hurt and need to be told they aren't to blame for their parents' addictions.

Families and alcohol — A legacy of love and pain p C1-C4

INSIDE

NEWS

Briefly...

Druggists protest

BOMBAY — A move by the government here aimed at getting jobs for the estimated 12,000 unemployed pharmacy graduates is being met by protest from drug store owners. The owners, saying their costs will soar if they are forced to hire only qualified pharmacists, have retaliated by closing their stores for three days and closing in the evenings when most other shops are open. *The Globe and Mail* reports that the hiring law has been on the books since 1947 but has not been enforced. The owners say most prescription drugs are prepackaged, so the work involved does not require a university education.

Vodka boycott

WARSAW — Thousands of people here have taken a sobriety pledge, boycotting vodka in a protest against the government, which church and Solidarity activists say is not doing enough to combat the high rates of alcohol abuse. The pledge, taken at special masses throughout the country in August, was also expected to hit Poland's most profitable industry, reports the *Associated Press*. It is estimated that each Pole drinks more than 18 pints of pure alcohol a year and as much as one-third of the yearly family food budget goes to alcohol. In a recent public opinion survey, Poles said they felt more endangered by the threat of alcoholism than by another world war.

Australia's worry

SYDNEY — Drug taking and trafficking are considered the second biggest problem facing Australia, according to a recent Gallup poll here. Youth unemployment topped the list of national problems in the survey of 2,036 people across the country. Alcohol tied for sixth spot with road deaths and sexual attacks. Smoking came at the bottom of the 13 choices offered.

Computing health

SAN DIEGO, Cal — The computer craze has now entered the fitness field with a software program for home computers that helps users examine and monitor chemical dependency, physical activity, nutrition, weight control, and stress management. Called Positive Lifestyling, the program measures wellness through various tests, examines lifestyle, and gives feedback on how that lifestyle is affecting long-term health. The user can set goals, and a personal fitness and health plan can be monitored daily via computer.

Programs paying off

TORONTO — Successful drinking and driving campaigns are responsible for the 18.1% reduction in highway fatalities in the province, says Ontario Transportation and Communications Minister James Snow. In the first six months of this year, highway deaths dropped to their lowest levels since 1960, and 95 fewer deaths were reported than in the same period last year. Mr Snow told *Canadian Press:* "I suspect society at large is no longer willing to accept or tolerate people who drink and drive. It's been a long time coming, but I'm convinced it's a critical factor."

One-year licence suspension for first offenders

NS drunk-driving plan cheap, effective

By Betsy Chambers

HALIFAX — Nova Scotia has joined the growing list of governments cracking down on drunk drivers and finds its stance not only popular, but relatively cheap to implement.

In a province with a rising deficit, and a net direct debt of $2.2 billion, NS Attorney General Ronald Giffin admits any program that can combine thrift with popularity is a political winner.

Since May, when the campaign against drunk driving began, Mr Giffin says he has been stopped on street corners by people congratulating him on his efforts. "We've had letters and phone calls too," offering support he said.

On the ledger side of the issue, the main cost incurred has been a $50,000 committment to purchase breath-testing equipment for the nine of 26 municipal police forces now without it.

"All you would need is 100 convictions, and you have the $50,000 back easily" in fines, Mr Giffin told **The Journal**.

Another $50,000 has been used to encourage high schools to hold alcohol- and drug-free graduation parties. "There have been no major new costs," he said.

The government action has pleased Marvin Burke, executive director of the provincial Commission on Drug Dependency here, who says he has been trying to interest government in attacking the drunk-driver problem for more than a decade. Mr Burke is optimistic the number of policy initiatives on the issue will support the holistic approach favored by the commission.

New government legislation came into effect July 1, revoking for one year the driver's licences of convicted drivers on a first offence. This is in addition to the $50 to $2,000 fine imposed under Canada's Criminal Code.

The get-tough attitude has been reinforced with a commitment to fund training and provide breath-testing equipment to municipal police forces now without them. Police generally are also being encouraged to apprehend more drunk drivers.

While judges continue to use their discretion in sending first-offenders to the commission for drug-dependency assessment, it is now mandatory on second or subsequent convictions. The findings are reported to the Registry of Motor Vehicles which may require an applicant to enter a commission education program before it reissues the driver's licence. The applicant now has to pay $100 to obtain his licence again.

Earlier this year, the department of education offered $500 to each vocational or high school's graduating class if they agreed to organize and hold a chemical-free end-of-year party. Sixty of 90 schools in the province participated and the program was deemed a success.

To increase public awareness of government efforts, cabinet press secretary Dick James was seconded to the attorney general's office to coordinate the program. Bumper stickers are now common with the admonition "Drunk Drivers get caught in Nova Scotia," and similar warnings are posted at entry points into the province.

"If they raise the level of consciousness, it's a beginning," Mr Burke told **The Journal**. "All the literature done on this business of drinking and driving shows that the message decays very quickly."

But the publicity may be self-generating. The Premier's Task Force Against Drunk Drivers has now been established, bringing together representatives of the commission, the departments of transportation and education, and the attorney general's office to examine such issues as liquor advertising, the drinking age, and coordination of anti-drunk driving programs.

Chairman is the attorney general, who reports directly to the cabinet. "We wanted to make sure it wasn't doing its deliberations in a vacuum" Mr Giffin said.

Mr Burke interprets the committee's structure as a signal the government means business.

Meanwhile, interest in what Nova Scotia is doing about its drunk-driving problem has increased, said Mr Giffin. Inquiries are coming from outside the province, and he planned to give a full report to colleagues at the next provincial attorneys general meeting.

The drive to take action on the problem this year was a result of a combination of factors, Mr Giffin said. He moved into the attorney general's portfolio nearly a year ago, after a two-year period heading up the department of transportation. "I had seen what was happening" on the highways.

Mr James, the former cabinet press secretary, teamed up with Mr Giffin to produce a televised address on the subject during a routine political broadcast. It brought such response, Mr Giffin was encouraged to bring the matter to cabinet. "We definitely plan to move ahead on the issue," he said.

Pope talks to kids about drugs

MONTREAL — Pope John Paul II has made a plea to Canadian youth to reject the "artificial paradise" of drugs.

At a rally here of more than 50,000 Quebec young people aged 15 to 25, the Pope asked listeners to "have the courage to resist the dealers in deception who make capital of your hunger for happiness, and who make you pay dearly for a moment of 'artificial paradise' — a whiff of smoke, a bout of drinking, or drugs.

"What claims to be a shortcut to happiness leads nowhere," he said. "It turns you away from that intelligent self-discipline which builds up the person."

Pope: courage to resist

Heroin as medicine gets approval of CMA

(from page 1)

"I think the chances of the government accepting it are excellent. A new broom always wants to do some sweeping."

As chairman of the CMA council on health care, it was Dr Ghent who guided the motion through the CMA general council.

"I'm surprised it got through," he said at a press conference. "To undo a demonization process of 35 years in a two-hour presentation is quite an accomplishment."

He wasn't so lucky with a second recommendation that the CMA and the federal and provincial governments jointly establish a centre for the study and treatment of opioid addiction, and that it contain a major research group in both basic and clinical science.

That was referred to the board of directors "for financial consideration," mainly because the delegates didn't know how much such a centre would cost the CMA, and Dr Ghent couldn't tell them.

"If we can spend half a million dollars on politics, we can spend some on a health problem costing society almost as much as health care. We're good at suggesting others do things . . . There's been a total medical cop-out. We've allowed addiction to become a crime."

Reiterating that it was the US that urged the World Health Organization to call for the 1950s ban, and Canada complied, he said: "We followed the US like sheep, and now we've got their manure to deal with."

The ban was imposed "with the naive assumption by government and its police forces that if all heroin was illegal, prosecution would be easier and the illicit use of the drug could be eradicated." Canada had about 4,000 heroin addicts in 1954 and an estimated 18,000 in 1980, Dr Ghent said.

His council's report quoted minutes from the CMA annual meeting of 1950, opposing a ban on heroin for medical use, and correspondence with government officials later confirming that stand.

It also quoted Hansard (report of proceedings in Parliament) during the ban debate when Paul Martin, then minister of Health and Welfare, said: "There are alternatives (to heroin for pain control) . . . We have discussed this with the CMA and the best medical skill that we have in the country, and that is their judgement. The decision was based upon that advice and on our obligations as a member of the United Nations."

"Did that advice come from the CMA?" he was asked.

"We discussed it with the CMA," he replied.

"I am satisfied," said the questioner.

A number of delegates who opposed the motion wanted to wait for the results of the multi-centre, double-blind trial of heroin among about 1,000 terminally ill cancer patients, being funded by the federal government. But, a motion to that effect was defeated.

Others quarrelled with the objectivity of some of the report's conclusions, such as "parenteral heroin acts significantly faster than morphine," and "equal analgesia is obtained with heroin in one-third to one-half the dose of morphine."

Still others brought up the spectre of doctors and hospitals having to take elaborate security precautions to prevent break-ins.

Malcolm McPhee, MD, director of surgery at the Cross Cancer Institute in Edmonton, summed up the opposition.

"We really don't know enough about the drug itself. The body of knowledge of the last few years contradicts (Dr Ghent's) report.

"It's not the cancer patients and pain researchers asking for heroin. It's Dr Walker (who writes under the pseudonym Dr Gifford-Jones) and an emotional and uninformed movement to get the drug."

L. Jack Genesove, MD, of Willowdale, Ont who, like Dr Ghent, had used heroin in his practice, said: "We could spend 50 years debating what's the best pain killer. Let's be very scientific. Pain control drugs are hard to prove scientifically. This is a bad scene (the ban) and we shouldn't be part of it. Put it back for doctors to use it."

Thomas G. Dickson, an otolaryngologist from Brampton, Ont, said he regularly uses cocaine in his practice, and "I'd be upset if someone told me that because it's used illegally, I couldn't use it.

"Our teachers told us heroin was effective, and we found it so . . ."

Next month:
Excerpts from the Report of the Expert Advisory Committee on the Management of Severe Chronic Pain in Cancer Patients.

Health ministers target young smokers

CALGARY — Canada's provincial health ministers have announced they intend to focus a number of smoking prevention programs at the 12- to 17-year-old age group during the International Year of the Youth next year.

The decision to target this age group was made at the annual meeting of the health ministers here and was the initiative of Saskatchewan Health Minister Graham Taylor.

It is the second year in a row that Mr Taylor had asked to place the issue of smoking on the ministers' limited agenda.

Prior to discussing the issue, Mr Taylor told The Journal: "It would be very good if we as ministers could target on the youth population, especially teenage girls."

Although he indicated it would be good if the ministers would commit themselves to a specific percentage of youths that would stop smoking during the year, they did not go that far.

Mr Taylor also said he would inform the other health ministers about the "very positive results" the provincial government has had in promoting non-smoking in schools.

He said there are now 10 high schools in Saskatchewan that are completely smoke-free, and smoking is prohibited for both students and teachers. In some other schools, smoking is not allowed on the premises.

In an attempt to have stop-smoking programs come from the students themselves rather than being imposed from above, he said the province awards $100 to student councils that develop initiatives to decrease smoking.

Care-givers need alcoholism training

By Maureen Brosnaham

WINNIPEG — The majority of professionals and others working in social service agencies have little or no training to detect or help alcoholics, says a professor of social work at the University of Manitoba.

"I think in Manitoba we have one huge problem. I think we have a crisis on our hands," Walter Driedger told the Current Issues in Chemical Dependency Conference here.

"It seems to me that care-givers in this province categorically . . . think that alcoholism (training) is something that is optional."

He estimated that 60% of those working in the social services field have little knowledge of alcoholism or how to detect it. He said many choose to ignore it, not realizing it can be fatal.

Mr Driedger said alcoholism affects about 10% of the population and is even more prominent among clients of social service agencies.

Yet, he said, few of those who work in social agencies are willing to tackle the problem. Instead, he said they try to solve other problems, such as unemployment or family and marital problems, without dealing with the alcoholism.

"Most agencies have neither a developed policy or sufficient staff with knowledge of alcoholism . . . my hypothesis is that things are not that great in Manitoba."

Mr Driedger said social service agencies should provide more in-service programs on alcoholism, and medical and social work schools should spend more time teaching their students about it.

William Jacyk, MD, chairman of the Manitoba Medical Association's Physicians at Risk Committee, also said training for medical students is inadequate.

He said while doctors are taught the physical complexities of liver disease, their ability to diagnose alcoholism is poor.

"I think there's just total ignorance of what they are dealing with," he said.

Dr Jacyk said one United States study estimates that one in every five patients who goes to a doctor is dependent on some chemical. "I can assure you that one in every five is not referred," he said.

As well, Dr Jacyk said, 25% to 35% of all patients in hospitals are chemically dependent and many of them miss being diagnosed.

"The difficulty with physicians is we were taught a technical approach, to test . . . to come up with a yes or no answer," he said. "But unfortunately it's difficult to come up with a yes or no answer."

Dr Jacyk said most patients with drinking problems won't admit to them. When questioned about their drinking habits, they will underplay them or deny any problem.

All most of them want is a prescription or a drug to ease their pain, not help their dependency. The hardest thing for a physician to do is resist reaching for the prescription pad, he said.

Brad Scibak, a junior high school counsellor in Winnipeg, said parents and teachers must also be alerted and made aware of drug and alcohol problems among young people. He said such problems are a fact of life and ignoring them could have tragic consequences.

"The kids who are the problem drinkers are going to be the adults who are problem drinkers," he said.

CMA condemns steroids for athletes

EDMONTON — Use of anabolic steroids and growth hormones by athletes has been condemned by the Canadian Medical Association (CMA).

The CMA council on health care noted that some physicians connected with athletic clubs have been prescribing these drugs to those who think th' will enhance athletic performance.

The motion to condemn this use was passed at the CMA annual meeting here without discussion.

The council noted that since testing athletes for these drugs is becoming more common, "eventually the tactic will lose its popularity."

Typical user is young, male, well-educated

Ontario study reveals light cocaine use

TORONTO — About 3.3% of Ontario adults have used cocaine at least once in their lives, says an Addiction Research Foundation (ARF) study — Alcohol and Drug Use Among Ontario Adults in 1984.

This was the first time a province-wide sample of Ontario residents aged 18 and older was asked about their cocaine use.

Among users, 54% reported using cocaine at least once in the past year. Of those, 41% reported infrequent use (less than once a month).

The typical user, the study says, is young (18 to 29 years old), male, and well educated.

The Ontario figures are low in approximate comparisons to United States figures. There, a 1982 household survey found that 28.3% of adults aged 18 to 25 years and 8.5% of those 26 and more reported having used cocaine at least once.

The Ontario survey shows 7.1% of those 18 to 29 years, 3% of those 30 to 49, and 0.4% of those more than 50 years reported using cocaine at least once.

"Although estimates of cocaine use among the Ontario student population have been readily available," the report says, "there has been a dearth of knowledge regarding the extent of cocaine use among Ontario's adult population, which may be at the most risk."

Prior to this survey, data from the federal Bureau of Dangerous Drugs showed that cocaine convictions had doubled between 1978 and 1982 to 1,155 from 507. The inclusion of cocaine use data in the ARF survey will allow analysis of trends in the future.

Foundation researchers also asked the 1,051 adults in the survey about their use of alcohol, sleeping pills, stimulants, tranquillizers, and marijuana/hashish. These adult surveys have been conducted since 1971 and cover urban and rural areas throughout the province.

Only the prevalence of alcohol use increased significantly in 1984 compared with the last Ontario survey in 1982. This year, 84.5% of respondents reported drinking in the past 12 months compared with 77.6% in the previous survey.

However, the percentage of respondents reporting heavy drinking (five or more drinks per occasion) declined significantly between the two survey years; to 49.2% in 1984 from 57.8% in 1982.

There was also a significant decrease in those reporting getting 'high' or 'tight' when drinking, with 40.3% in 1984 compared with 50.3% in the previous survey.

The 1984 survey showed that 11.2% reported using marijuana in the past year compared to 8.2% in 1982.

Although marijuana use didn't change significantly between the two survey years, the study says there was "a significantly greater percentage of infrequent users in 1984 than in 1982 . . . Those who do report use appear to be using it less frequently."

Tranquillizer use had dropped significantly in 1982 from the previous study and has maintained that level in 1984. Users tend to be female and more than 30 years old, the study says. Diazepam (Valium) remains by far the most widely-used tranquillizer.

The study also showed that 7.3% of those surveyed reported using sleeping pills at least once in the past year compared to 6.2% in 1982. About 2.5% used stimulants in 1984 compared to 3.3% in the previous survey.

'Round' etiquette — not as silly as it looks

By Wayne Howell

Aphorisms about groups of people or citizens of a particular country that are not obviously based on malice usually contain some truth. The British really are reserved, the Swiss neat, the Germans highly organized, and so on and so forth. Traditionally, the Irish have had the reputation of enjoying a few more pints than are really good for them. As W.C.P. O'Flynn, an Irish industrial physician, put it in the September 1984 issue of **The Journal**, "there's a peculiar attitude to alcoholism: 'he's all right, he just takes too many.' "

Some years ago, I met an Irish emigrant who had an unusual theory about "Irish drinking" and why it often became excessive. He had spent most of his life in Belfast and in various parts of the Republic. He liked to drink. But he had stopped going back to Belfast to visit his relatives and old friends, because he could no longer stand the drinking culture and its heavy emphasis on "rounds."

The "rounds" system is by no means exclusive to Ireland; it can be seen in operation at any Canadian tavern. But, according to my friend, it had reached its apotheosis in Ireland. (I can offer no statistics to support this assertion, but it seems reasonable to me, since on my four brief excursions into pubs on the Emerald Isle, I was invited to be involved in a rounds situation on three of those occasions.)

I will try to summarize the rules of rounds:

1) Someone buys a round — usually someone with a vested interest in getting a party going or seeing that the group's consumption approaches that of his own.

2) The second person buys the second round, the third person the third, and so on, until each person has paid for his own drink, plus one drink for all the others.

3) It is almost impossible to get out of a round. If you try to buy your way out, no one will take your money, and you will be treated as spoil-sport or a pariah.

4) Although there is no face-saving way of getting out of a round before it is over, new recruits are always welcome to join the round; theoretically, it could go on forever.

5) If the round does come to an end, and you have a decent excuse for not staying, you can leave and still maintain your "drinking dignity."

6) However, by the time the round comes to an end, and you have slopped down four or five pints that you really didn't want in the first place, you realize any sort of productive activity is now beyond you and are therefore inclined to stay for "just one more round."

Although round-etiquette looks benign — even silly — on the surface, there is an undercurrent of social blackmail. If a person has a need or wish to be accepted by the rounder group, and if he is not assertive or very self-confident, he can easily find himself drinking more than he really wants to on a regular basis. When I was young, I had a summer laboring job which terminated every night with rounds in a tavern. My need to be accepted by my co-workers, and to prove that all students were not wimps, made me very susceptible to the blackmail that is at the heart of rounding. I might have become an accomplished rounder, had not the nightly exercise been terminated for an unrelated reason: one night, when I went to purchase my round, the proprietor asked me for my birth certificate.

In later years, I held the same job, but when I wanted to extricate myself from a round situation I did so: I just put what I owed on the table and left. But it is interesting that the main reason I felt comfortable doing this was not because I was older — and therefore presumably wiser — but because I had proven myself to be a good worker on the job. Since, by that time, the group had accepted me as a laborer, I no longer felt I needed the group's approbation as a drinker.

My Irish friend was no insecure kid searching for acceptance in the world of working men. He was a successful middle-aged man. Yet, rather than buck the tyranny of the rounder groups among his family and friends in Belfast, by leaving when he felt he'd had enough, he chose to avoid the situation entirely by avoiding Belfast. He was convinced that the rounds system in Irish pubs was in good part responsible for alcohol problems in Ireland. He may have overstated the case — but his own behavior (avoiding Belfast) certainly suggests that he was genuinely discomfited by the situation.

NEWS

RESEARCH UPDATE

Alcohol/tobacco combo may impair vision

Cyanide has been pinpointed as the toxic substance responsible for causing visual failure in a condition known as tobacco amblyopia which often strikes patients who have been smoking and drinking heavily for several years. Researchers from the departments of neurology and clinical chemistry, Guy's Hospital, London, reported three cases of patients who presented with painless bilateral visual failure due to tobacco amblyopia. Cyanide levels in the blood were shown to be raised to levels above those predicted from patients' high tobacco consumption and were approaching lethal levels. Each patient had biochemical evidence of hepatic dysfunction caused by excessive alcohol intake. Visual symptoms in all patients improved following abstinence from alcohol and tobacco and therapy with hydroxycobalamin, which renders the cyanide non-toxic. The researchers hypothesized that while high concentrations of cyanide in tobacco smoke can be tolerated, chronic accumulation of cyanide sufficient to damage optic nerve fibres occurs when the cyanide detoxification process is impaired by damage to the liver through heavy drinking, in addition to high tobacco consumption. They concluded that whole blood cyanide measurements are useful in the diagnosis of tobacco amblyopia and also in tracing the subsequent clinical course of the disease following treatment.

Journal of Neurology, Neurosurgery, and Psychiatry, June 1984, v.47:573-578

FAS children show improvement

Children diagnosed as having fetal alcohol syndrome (FAS) improve over time in their psychiatric status and cognitive functions, a German study has demonstrated. Of a group of 49 children diagnosed with FAS, 28 were given a follow-up psychiatric assessment. Of these, 16 also had intelligence testing, and 13 were tested for psycho-linguistic abilities an average of 36 months (3 years) after the initial evaluation, when they ranged from 46 (3 yrs 10 mos) to 159 months (13 yrs 3 mos). A structured psychiatric interview, the Columbia Mental Maturity Scale, and the Illinois Test of Psycholinguistic Abilities were used and showed a significant improvement in the group, although the children were still significantly more impaired than a control group. Specific areas of improvement included motor functioning, attention, relations with siblings and peers, temper, phobias, intellectual performance, and psycholinguistic abilities. No improvement was seen with hyperactivity, a prime symptom in FAS children. Since progress in development was independent of social environment, sex, age, and therapeutic measures, the researchers from the Free University in Berlin concluded "maturation and development are quite clearly the major forces which are responsible for this welcome compensation of deficiencies."

Journal of the American Academy of Child Psychiatry, July 1984, v.23:465-471

Smoking/breast cancer theory countered

A study of more than 2,000 women indicates there is no support for the hypothesis that smoking reduces the incidence of breast cancer. Recent suggestions that smoking may do just that by reducing estrogen levels were tested by Boston researchers. The case-control study examined 2,160 women with breast cancer and 717 controls admitted to hospital for cancer of the ovary, colon, or rectum; malignant melanoma; or lymphoreticular cancers. Researchers found the smoking habits of patients with breast cancer were similar to those of the controls. Results did not change even when potential confounding factors were taken into account. "However, since women who smoke reach the menopause a year or so earlier than non-smokers, and since the incidence of breast cancer declines with decreasing age at menopause, a more modest protective effect is plausible and is not ruled out by the findings," the study noted. The research was conducted by the drug epidemiology unit, school of public health, Boston University School of Medicine; department of medicine, clinical epidemiology unit, University of Pennsylvania; and the epidemiology and preventive medical service, Memorial-Sloan Kettering Cancer Center, New York.

New England Journal of Medicine, Jan 12, 1984, v.310:92-94

Jimson weed abuse serious

Jimson weed abuse should be considered as a potentially serious form of substance abuse in adolescents and young adults, two Baltimore researchers have concluded. Wendy Klein-Schwartz, PharmD, and Gary Oderda, PharmD, chronicled 73 cases of jimson weed exposure reported to the regional Maryland Poison Center, from 1978 to 1982. The mean age of the subjects was 17.3 years with a range of 11 to 28 years, and the male-female ratio was 5.4:1. In almost all cases the exposure was attributed to drug abuse or experimentation and the drug was taken orally, with visual and/or auditory hallucinations the most frequently reported symptoms. The majority (81%) of patients in the study group required medical care, including attempts to minimize absorption of the jimson weed from the gastrointestinal (GI) tract in 30 cases, and treatment with physostigmine in 23 cases, primarily because of severe hallucinations. "Abuse of jimson weed should be considered in adolescent patients with the acute onset of hallucinations and other anticholinergic symptoms," the report concluded. The researchers said overdose cases should be managed by providing supportive care and gastro-intestinal decontamination. Physostigmine should be given only in cases of serious intoxication, because of the potential for toxic reactions.

American Journal of Diseases in Children, August 1984, v.138:737-739

Pat Rich

Drug awareness messages getting concentrated effort

By Terri Etherington

TORONTO — Efforts by the Canadian Addictions Foundation (CAF) to foster a national addiction awareness week have not materialized, but most of the provinces and territories are planning such events nonetheless.

Ontario will be first, with an Addiction Awareness Week slated for October 21-28. It will be followed by similar events in November in all four Atlantic provinces, Saskatchewan, the Northwest Territories, and possibly The Yukon.

Henry Schankula, director of education resources for Ontario's Addiction Research Foundation (ARF) and chairman of the CAF publicity and public relations committee, told **The Journal** the CAF had applied to the federal government for funding for a national awareness effort but was not successful in its appeal.

Mr Schankula said the CAF wants to encourage development of a coordinated national effort but would take a "nurturing rather than dictatorial" approach. "It is not a necessary requirement that they all happen at the same time," he said, "but there are obvious advantages," including attracting the media on a national focus.

"It puts things in focus, whereas at other times of the year addiction awareness may be on the peripheral edge of newsworthiness."

In Atlantic Canada, efforts have been concentrated in a regional approach since 1981, although each province selects a theme and program suited to its particular needs.

In Nova Scotia, the theme, "Kids Care" aims to help young people learn to share their concerns with friends and parents.

In New Brunswick, the slogan "Kids care whether you drink and drive" ties in with other provincial efforts against drunk driving. Achille Maillet, director of community services for the NB Alcohol and Drug Dependency Commission, told **The Journal**: "We are appealing to adults through kids."

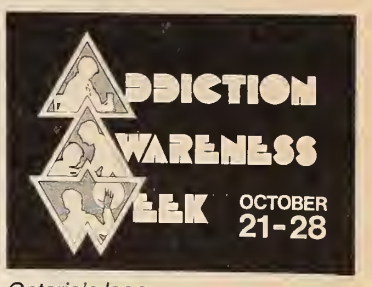
In Newfoundland and Labrador, the theme "Growing up in the 80s" will focus on early prevention of drug problems. The campaign will centre on children from infancy to 12 years through media and community activities for them and their care-givers, Gary Roberts, director of education for the Alcohol and Drug Commission of Newfoundland and Labrador, told **The Journal**.

In Prince Edward Island, Heather MacPherson, education coordinator, Addiction Services, says the theme will be "Drug awareness is everyone's business."

Elaine Scott, acting executive director of the Saskatchewan Alcoholism Foundation, says the week of November 18 to 24 was chosen to coincide with events in the Maritimes adding, "we want to try to fit in with a national approach." The theme is "There is a better way."

The Northwest Territories week, also slated to coincide with the Atlantic provinces, will focus on early detection and early warning signs of alcohol abuse. Winnie Fraser-MacKay, coordinator of Alcohol and Drug Services, says each community plans its own activities with guidance and resource materials available from headquarters.

In The Yukon, tentative plans call for a drug awareness week in November to tie in with other provinces.



Ontario's logo

In Ontario, the event is a cooperative effort with the ARF joining other community groups, including the Alcoholism Recovery Homes Association, the ministry of education, the Drug Education Coordinating Council, the Salvation Army, Parents Against Drugs, and the Donwood Institute. A 10-kilometre run, public forum and workshops, mall displays, flag raising ceremonies, children's art displays, and media events in Toronto as well as several other Ontario communities, will focus on the slogan "Think about it — talk about it."

Says Joe Taylor of the Alcoholism Recovery Homes Association — a group instrumental in starting addiction awareness week in Ontario several years ago: "We recognized that although there were a number of different agencies and people out there making the general public aware of the various problems of addiction, the coordinated effort brought them all together in one focus."

No special weeks are planned in British Columbia, Manitoba, or Alberta. **The Journal** was unable to get a response from the ministry of social affairs in Quebec.

Heroin, cocaine offences increase

Cdn drug crimes drop by 15.2%

OTTAWA — For the second consecutive year, Canadian police report a significant decrease in the number of drug-related crimes.

Offences under the Narcotic Control Act and the Food and Drugs Act declined by 15.2% to 54,791 in 1983 from 64,636 in 1982, according to a recent report from Statistics Canada's Canadian Centre for Justice Statistics.

The figures, which represent the number of crimes reported by police, regardless of disposition, showed an 18.5% decrease in cannabis offences, but heroin offences were up by 28.5%, and cocaine crimes increased 19.5%.

In 1983, police reported 43,747 cannabis offences compared with 53,690 in 1982, representing decreases in possession and trafficking, but small increases in both importation and cultivation offences.

Statistics for other drugs show: heroin up to 943 offences in 1983 from 884 in 1982; cocaine up to 3,272 offences from 2,738; controlled drugs down to 884 offences from 1,061; restricted drugs up to 3,183 offences from 3,091; and other drugs down to 2,762 offences from 3,354.

Provincial liquor law violations showed a drop to 294,988 in 1983 from 326,901 in 1982.

Prince Edward Island was the only province reporting an increase in drug crimes; up 33.2% over those reported by police in the previous year.

Decreases in the other provinces and territories were as follows: Newfoundland, 23.8%; Nova Scotia, 38.7%; New Brunswick, 7.3%; Quebec, 6.9%; Ontario, 24%; Manitoba, 9.7%; Saskatchewan, 10.5%; Alberta, 16.5%; British Columbia, 0.2%; The Yukon, 42.8%; and Northwest Territories, 17.3%.

Overall, Criminal Code offences reported by police in Canada during 1983 decreased 2.7% from the previous year, the first such decrease since the inception in 1962 of the Uniform Crime Reporting Program.

Violent crimes across Canada increased by 1.2%, but robberies were down 11.2%, and property crimes declined 3.2%, as did fraud 0.3%, and other Criminal Code offences, 2.7%.

MDs favor drink-age hike to lower youth death toll

EDMONTON — The Canadian Medical Association (CMA) has endorsed raising the legal drinking age to 21, because doctors say the move will reduce traffic deaths among young people.

"There's no question in the world that lowering the drinking age in Canada has meant an increase in deaths," Norman Hamilton, MD, of North Vancouver told the CMA general council at its annual meeting here.

He said there had been an average 28% reduction in deaths among young people in the 14 states in the United States that raised their drinking ages. In British Columbia alone, that would mean 35 fewer deaths of young people each year.

The only physician to argue against the motion did so on the basis that it was "highly unrealistic and inapplicable."

Since the drinking age is under provincial jurisdiction, the recommendation will be passed on to provincial governments through the CMA's provincial divisions.

The association also wants federal and provincial governments to be more active in prevention of alcohol-related morbidity and mortality.

Recommendations, drawn up jointly with the Canadian Nurses Association, call for labelling of alcohol as a possible health hazard, control of alcohol advertising, more education programs, and public use of breath analysis tests.

The CMA also endorsed a motion calling for more specific labelling on all medicines. This may assist alcoholics taking Antabuse (disulfiram) since a number of non-prescription drugs contain alcohol. Because alcohol is considered an inactive ingredient, manufacturers have not been required to list it on the label.

Caffeine:

history, habits, and health

Second of a two-part series

This part of the two-part series will focus on caffeine's effect on health. First I want to discuss tolerance to and dependence on caffeine, and the effects of caffeine on sleep. Then I shall deal with what most captures the public eye and ear in the story of caffeine: the relationships between use of it and the incidence of cardiovascular disease, cancer, and birth defects.

Tolerance

The first properly designed study of caffeine tolerance in humans appeared in 1981. Dr David Robertson and four colleagues examined the effects of thrice-daily, 250-milligram oral doses of caffeine on healthy subjects who used caffeine regularly but had abstained for three weeks and had no caffeine in their blood at the time of caffeine administration.

Using a double-blind design, the experimenters found that the many acute effects of caffeine — it caused increases in blood pressure, plasma epinephrine, plasma norepinephrine, plasma renin activity, and urinary catecholamines — had all disappeared by the third day.

Recent animal studies have provided evidence of tolerance to caffeine's effects on behavior, on brain activity, and on body temperature. In the last study Dr Arthur Scholosberg found that low doses of the drug produced hyperthermia in rats, with no tolerance to this effect, but that high doses produced hypothermia for the first few days and then hyperthermia — ie, with repeated administration, the effect of high doses became like that of low doses.

Drs Curatolo and Robertson argued in their review — quoted at the end of the first part of this series (**The Journal**, Sept) — that much of the confusion in the literature concerning caffeine's effects can be attributed to failure to account for tolerance to caffeine. I agree. I would add a further point. There is growing evidence that tolerance to psychotropic drugs is partially mediated by compensatory, physiological responses that become evoked by the usual drug-administration environment. Many individuals use caffeine in a wide variety of environments, including many unfamiliar places. In unfamiliar places there could be reduced conditioned compensatory responses, providing a further source of variability.

Dependence again

A person who consumes about 500 mg of caffeine a day, and shows no signs of this because tolerance to caffeine has occurred, may also be physically dependent on caffeine — meaning that if caffeine use ceased a distinct withdrawal syndrome would appear.

I described the withdrawal syndrome in some detail last month. The question now is whether dependence in itself is conducive to ill-health. This depends in part on one's definition of health. If dependence on a drug is by definition unhealthy then there is nothing to discuss. Certainly many members of the public describe drug dependence as intrinsically unhealthy.

As far as caffeine is concerned, however, there seems to be a level of regular use — around 400 mg a day for the typical, non-pregnant adult — that produces dependence but no short- or long-term ill-effects, as long as caffeine use is not increased or interrupted. Interruption can be disabling, chiefly on account of the profound headache that characterizes abstinence from regular use of caffeine.

Dr John Greden, who specializes in excessive caffeine use as a factor in psychiatric illness, has noted that "headache is one of the most common complaints encountered by psychiatrists" and that "caffeine-withdrawal headache . . . [is] . . . a common and important psychiatric entity." It begins, he continued, "with a feeling of 'cerebral fullness,' usually about 18 hours after the last caffeine ingestion, and quickly develops into a diffuse, throbbing, painful headache that is exacerbated by exercise. Discomfort peaks about three to six hours after onset."

Abstinence can occur inadvertently, perhaps because regular morning coffee is missed through late rising, itself the result of caffeine-induced insomnia. However induced, abstinence from caffeine can threaten the health of the caffeine-dependent person. A person undergoing caffeine withdrawal may be accident-prone, socially dysfunctional, and inclined to self-medication, none of which is consistent with good health.

Sleep

Dr Peter Dews noted in the 1982 *Annual Review of Nutrition* that "the function most sensitive to modification by caffeine in human adults is that of going to sleep." Many well-conducted studies have shown that 100 mg to 200 mg of caffeine before retiring will delay sleep onset, shorten sleep time, rearrange the phases of sleep, facilitate awakening during sleep, and generally reduce the quality of sleep.

Indeed, the effects of caffeine on sleep are sufficiently well-established and predictable that caffeine-induced sleep disturbance is used experimentally to test the effects of hypnotic drugs in studies involving human subjects.

Notwithstanding the frequent findings of caffeine-disturbed sleep in the laboratory and during other investigations, considerable individual differences have been found. Tolerance to caffeine has been implicated, as has personality, differences in the rate of metabolism of caffeine, and differences in sensitivity of sites of action of caffeine.

On the matter of metabolic differences, one recent study, by Israeli researchers Micha Levy and Ester Zylber-Katz, examined rates of clearance of caffeine from plasma in caffeine-sensitive individuals and found them to be an average of some 30% lower than in control subjects. Caffeine-sensitive individuals also drank less than average amounts of coffee. Whether differences in rates of clearance are inherited or the product of differential exposure to caffeine, or both, remains to be explored.

One contributing factor is known. Smokers metabolize caffeine 30% to 40% faster than non-smokers, probably on account of induction of liver enzyme activity in the course of the metabolism of nicotine and other tobacco-smoke constituents.

Racial differences in caffeine metabolism are currently a hot topic for research, particularly at the University of Toronto where Dr Werner Kalow has discovered consistent differences in the ratios of various metabolites of caffeine found in the urine of Orientals and people of European origin, and has been able to relate these to the activities of particular enzyme systems in the liver.

My hunch regarding caffeine's effects on sleep is that they are of indirect but profound importance in the causation of ill-health. The effects of chronic insomnia on health are themselves poorly documented, except perhaps the relation between insomnia and pyschiatric disorder. Regular, heavy use of caffeine appears to provide chronic diminution of the quality of sleep, even when the users are not aware of it.

Cardiovascular disease

Two studies of a possible caffeine effect on the cardiovascular system have caught the news since the review by Curatolo and Robertson was published. In April 1983, the *New England Journal of Medicine (NEJM)* carried a report by David Dobmeyer and four others of a study of oral or intravenous caffeine administration on the production of cardiac arrhythmias. Caffeine provoked arrhythmias in all five of the 12 subjects who had previous arrhythmic symptoms.

An accompanying editorial noted that arrhythmias are being implicated increasingly in sudden cardiac death, but it only weakly endorsed the authors' conclusion that patients with arrhythmias should avoid caffeine. Instead, the editorial warned: "The physician should take care not to diminish life's pleasures when there is no sound basis to do so, lest he or she be deemed a modern-day Savonarola."

The other study was also published in the *NEJM* — in June last year. Dr Dag Thelle and two colleagues reported on the Tromso Heart study of the blood lipid levels of 14,581 Norwegian men and women in relation to their coffee use. They found a strong, positive correlation between total cholesterol and coffee use even after adjustment for age, body weight, physical activity, and cigarette and alcohol use.

The report elicited a slew of letters in another issue of the *NEJM*. The researchers were criticized because they had not controlled for diet (they had) or for stress (they did, indirectly). Five of the groups of letter writers produced their own, hithertho-unpublished data. Three found no correlation between caffeine-beverage use and total cholesterol. One found a relationship only in young people, and the fifth found one only in women.

Such variety in results has characterized most of the epidemiological data on caffeine use and disease. The basic problem remains one I discussed in a 1976 review of caffeine's effects. There are enormous differences in the caffeine content of cups of coffee. Caffeine content varies with cup size, the type and amount of coffee used, and the method of preparation. A study conducted at the Addiction Research Foundation in the mid-1970s found a six-fold variation in the caffeine content of cups of coffee as consumed. The variation in cups of tea was even greater.

Thus any study — such as the Tromso study and the other five that were contrasted with it — that uses cups of caffeine beverage consumed per day as basic data is incorporating so much 'noise' into the comparison it can only be surprising that any correlations are found at all.

It should not be surprising, given the gross imprecision of the measure of caffeine consumption employed in these epidemiological studies, that wildly conflicting results are found.

Cancer

The chemical structure of caffeine and some of its metabolites is similar to that of components of the genetic code, and caffeine is known to cause chromosomal aberrations and affect the ways in which cells and organisms reproduce themselves — indeed this property is exploited by cancer researchers. Thus, suggestions that everyday use of caffeine might be implicated in particular types of cancer should always be taken seriously.

Most concern in the past few years has been over the possibility that use of coffee or caffeine may be a cause of cancer of the pancreas, which ranks fifth, sixth or seventh among cancer sites in the mortality statistics of most countries.

A link between coffee use and pancreatic cancer was first proposed in 1970, after correlations were found between coffee consumption and pancreatic cancer mortality in 19 countries. A case-control study — one in which the coffee use of 369 pancreatic cancer cases in Massachusetts and Rhode Island was compared with that of 371 matched controls — was reported by Dr Brian MacMahon and four others in 1981. They found a strong association between pancreatic cancer and coffee use in both men and women.

More recent reports have both supported and contradicted the findings of MacMahon and colleagues. Most have focused on coffee, but some on tea and on the possible involvement of caffeine. No researcher, to my knowledge, has properly estimated caffeine use.

I should stress that the epidemiological and other evidence presently allows no clear conclusion as to whether caffeine beverages cause cancer, as they are ordinarily used. Thus while caffeine is a known co-carcinogen in animals at high concentrations (and also an anti-carcinogen under certain circumstances), its role in cancer production in human remains uncertain.

Birth defects

Officials of the United States Food and Drug Administration (FDA) made the following statement during 1983: "Recent studies that show that caffeine can induce birth defects in rats bring the safety of caffeine into question. Human studies neither support nor refute the findings in animals, and concern remains that caffeine may increase the risk of birth defects for humans. Because of this concern the FDA has proposed to remove caffeine from the list of substances generally recognized as safe and to regulate the added uses of caffeine to food and beverages on an interim basis, providing that additional studies are undertaken that relate to the questions of caffeine's safety. In the meantime, the FDA has recommended prudence on the part of pregnant women in the use of caffeine products, stressing that these further studies may take two to four years to complete."

This warning was slightly moderated by the FDA early in 1984, inadvisedly in my view, on publication of the first of the additional studies.

Epidemiological work in this area has produced contradictory results. Again, this should not be surprising because the basic data on caffeine use have been based on cups of caffeine beverage consumed. The reliance on reported cups of coffee or tea consumed as an index of caffeine use, without consideration of their size or method of preparation, is rather like relying on the number of published articles as an index of a researcher's contribution to an area of scientific endeavor, without consideration of the length or content of the articles.

By Richard Gilbert, PhD

For information on sources used in this series write the author, c/o The Journal, Addiction Research Foundation, 33 Russell St, Toronto, Canada M5S 2S1

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Ts and blues abuse dropping in Buffalo too, drug-maker says

I wish to refer to two statements, both included in the last sentence of the article, Ts and blues abuse dropping (**The Journal**, Sept).

First, please note that the data reported by Dr Senay at the June 2, 1984 meeting of the Committee on Problems of Drug Dependence (CPDD) refer to the first few months following introduction of the new, naloxone-containing Talwin (pentazocine) formulation in the United States.

As in other major US cities, including Chicago, Detroit, and Cleveland, a definite downward trend in pentazocine abuse could be observed in Buffalo as well, even during this relatively short period of time, contrary to the contention of the article.

In fact, data available from the US Drug Abuse Warning Network indicate a 25% overall decrease in pentazocine abuse in Buffalo, when comparing 1983 vs 1982 data. You will no doubt be interested in knowing that this definite downward trend continues unabated in 1984, specifically in Buffalo, as in other US cities, and that no evidence of across-the-border trafficking has emerged.

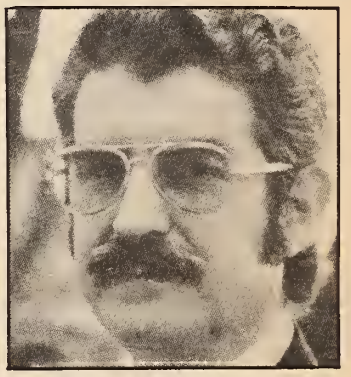
The other point I would like to address is the statement that the drug has not been reformulated in Canada. Our parent company has committed itself to world-wide introduction of reformulated Talwin, wherever local conditions and regulations permit.

In Canada, Winthrop Laboratories filed a New Drug Submission with the Health Protection Branch (HPB) for the new formulation back in April 1982. The reason given by the HPB for not allowing introduction of the new formulation to the Canadian market is that the additional ingredient (in this case, naloxone) does not provide added therapeutic benefit to legitimate patients.

A. Foldes, PhD
Director
Drug Regulatory and Technical Affairs
Sterling Drugs Ltd
Aurora, Ontario

Editor's note: The last sentence of the article reads: "The one city where there has not been a downward trend is Buffalo; drug users there have access to Talwin obtained from Canada where the drug has not been reformulated." The information contained in this sentence is based on information supplied to the CPDD conference by an official from the US National Institute on Drug Abuse.

Column on police tactics applauded by readers



Trebach: no one benefits

Congratulations to The Journal and to the editor for your short, but incisive, exposé of methods used by police to brutalize heroin users in British Columbia (The Journal, August). I have seen the results of some enforcement tactics first hand, and I believe Arnold Trebach has not overstated the case.

What is the strange quirk in our otherwise peaceful society that make this particular type of brutality seem justified? Can anyone provide evidence that anyone benefits from these police tactics?

Bruce K. Alexander, PhD
Professor
Simon Fraser University
Burnaby, British Columbia

I read the article by Arnold S. Trebach in the August issue of The Journal entitled, Is Canadian drug law truly this repressive?

Living in British Columbia, I am very familiar with the information about which Dr Trebach has written. It is a very revolting situation for the people who use heroin. They are treated as third-class citizens with no rights. They become political prisoners without harming anyone — for using the drug of their choice.

I know they could become respectable citizens if a doctor could treat them for their addiction.

Again I thank you for printing Dr Trebach's article, and I hope we will hear more from him.

Mary McInnis
Burnaby, British Columbia

Is spouse involvement an aid in alcohol therapy?

There has been a lot of controversy within our organization in the past two years concerning spousal involvement in treatment of alcoholism.

The clinics that are actively involved in the treatment of patients suffering from the disease of alcoholism feel that spousal involvement in the treatment program is essential and greatly enhances the success of the patient in maintaining sobriety. Unfortunately, the administrative heads do not agree and say that there is no proof that spousal involvement in treatment has any effect whatsoever.

Are you aware of any studies on spousal involvement in treatment? If there are any would you send us the titles and where we can obtain copies to present to our administration in an attempt to convince them of what we already know.

Douglas A. Cooper
Director
Prairie Region
Alcoholism Rehabilitation Clinic
Canadian Forces Base Winnipeg

Editor's note: An information package is on its way. Meanwhile, readers interested in this subject should turn to our special section in this issue, Families and alcohol: A legacy of love and pain. A bibliography is available. For details see page C4.

The Journal welcomes letters to the editor. Letters bearing the full name and address of the sender may be sent to: The Journal, 33 Russell St, Toronto, Canada M5S 2S1

Families and alcohol: A legacy of love and pain

'Well, well, one is never finished with one's family, it's like the smallpox that catches you as a child and leaves you marked for life.' **The Age of Reason** Jean-Paul Sartre

When Canadian social worker, youth counsellor, and author Margaret Cork published *The Forgotten Children* in 1969, her purpose was to broaden understanding among the medical and professional community about the impact of parental alcoholism on children. She wrote: "At all levels of research and treatment (children of alcoholics) have been grossly neglected." Self-help groups like Al-Anon and Alateen quite often stood alone to help families in times of crisis.

In 1981 in the United States, it was estimated that 28 to 34 million people are raised in alcoholic homes. Nearly 50% of these children will become alcoholic and 30% will marry an alcoholic.

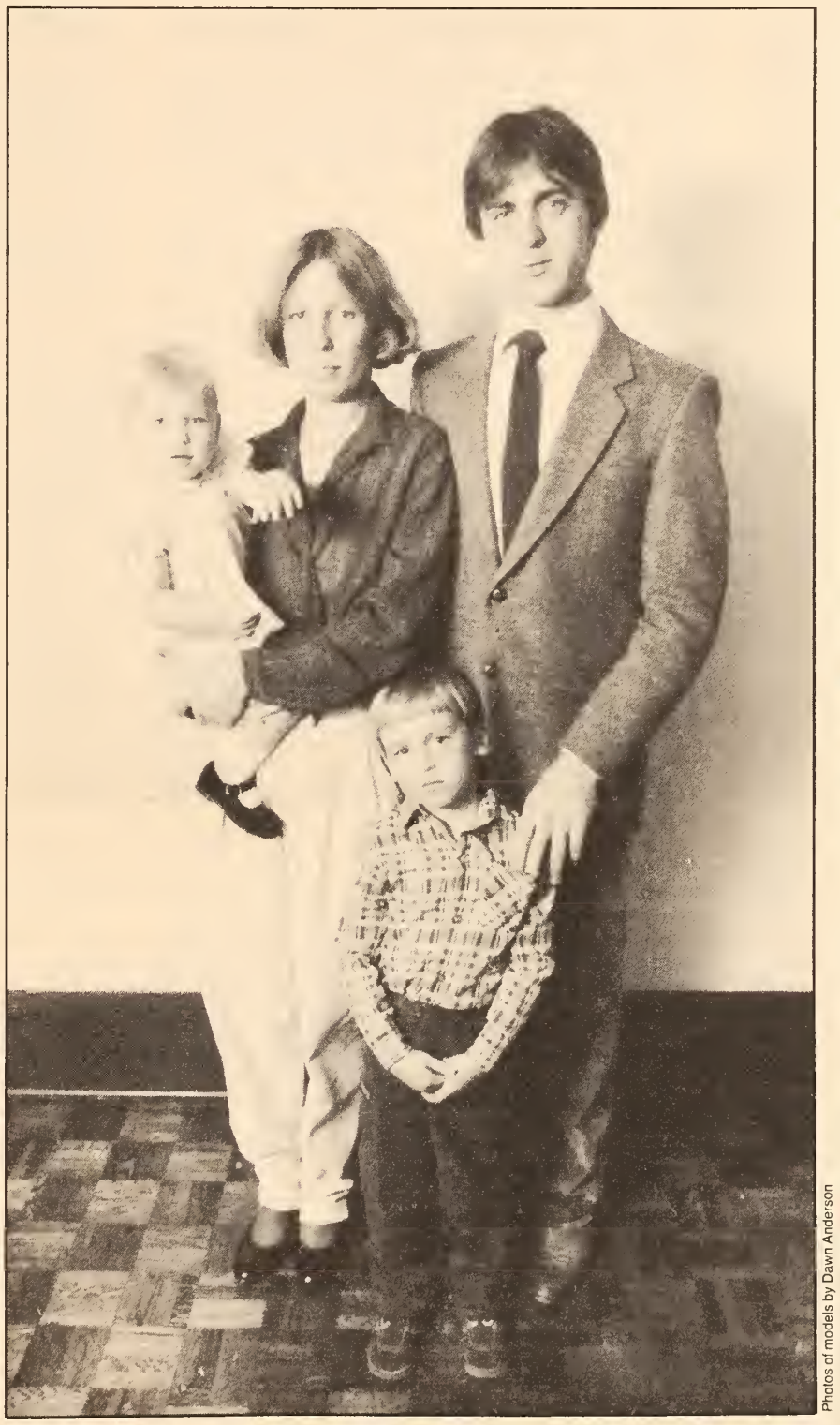
Now, 15-years after Cork's observations, the treatment needs of these children have been recognized, but clear-cut rules for therapy still are not established.

Nevertheless, the literature on children of alcoholics — from birth to adulthood — continues to grow as do self-help groups and regional and national organizations for the survivors of parental addiction.

The subject of familial alcoholism was deliberated throughout the four-day conference of the American Psychological Association annual meeting in Toronto in August. Therapists and psychologists presented their research and treatment approaches in the forms of prepared papers, symposia, a press conference, and a poster session.

Contributing Editor Karin Maltby was there for The Journal. In this special section she compiles excerpts taken directly from five papers presented at the conference.

Maltby



Photos of models by Dawn Anderson

The disease and its dilemma

By Sarah Reagan, PhD

People who love or live with alcohol- or drug-dependents are generally beset with an array of major and minor problems. Excessive alcohol use by one or more family members, for example, exposes others to such disruptive and stressful events as embarrassment in public, lack of adaptive social and recreational outlets, marital discord, sexual dysfunction, and inconsistencies in the execution of family responsibilities. Sometimes families suffer loss of income or become entangled in litigation because of alcohol-related problems. Acts of family violence such as spouse and child abuse, incest, homicide, and suicide are also often associated with alcohol abuse.

Children of alcoholics are four times more likely to become addicted to alcohol than the rest of the population. Clinical measures show no significant differences between children with only alcoholic mothers and children with only alcoholic fathers. However, children with two alcoholic parents appear to have more behavioral problems and more problems with aggression than children with only one alcoholic parent.

Children reared in alcoholic families present a variety of clinical complaints. Compared with children of non-alcoholics, they exhibit more school problems, hyperactivity, enuresis, stress-related illness, and suicide. They also seem to experience higher degrees of depression, anxiety, and guilt.

Reagan

As they grow into adulthood, children of alcoholics continue to show vulnerability to depression and stress-related disorders. They may be prone to compulsive disorders, such as "workaholism" or over-eating, have problems forming intimate and trusting relationships, be more likely to be antisocial or violent than other young adults, and they may experience early death.

Spouses and lovers of those who are chemically dependent also appear vulnerable to stress-related illness and compulsive disorders; experience high levels of anxiety, fear, guilt and depression; and may themselves abuse mood-altering drugs, including alcohol, sedatives, and tranquillizers. In fact, it's been argued that spouses of alcoholics, if not given appropriate treatment, sometimes become consciously or unconsciously suicidal.

Obstacles to problem resolution

Not identifying the problem as alcohol abuse — Clinical experience suggests not knowing that alcohol is the problem is especially harmful to children.

As a child, Mary thought her mother's "fits" (as she called her mother's outbursts of temper and violence) were related to whether she was a "good" or "bad" little girl. At an early age Mary developed a pervasive lack of trust and feeling of insecurity because of her mother's unpredictable manner. She didn't understand that her mother was responding to mood-altering chemicals, not just to her own "goodness" or "badness." Try as she might, Mary couldn't determine how to get a consistent or predictable response from her mother.

Denial of the problem — Denial, which infects not only the addicted person but those close to him, takes many forms, such as minimizing the amount or effects of drinking, blaming someone else for the negative consequences of a loved one's drinking, explaining away the effects of alcohol abuse by attributing them to some other cause. Health professionals are not immune to this phenomenon and may be unaware of a patient's chemical abuse.

Failure to recognize and treat alcohol addiction as a primary illness — People who do not understand that alcoholism is a primary illness may try to solve a problem which is merely a symptom of the problem. Depression, anxiety, sexual dysfunction, and social isolation are but a few of the symptoms of the primary illness of alcohol addiction.

Even when family members realize that addiction is the primary problem, they may not realize it is a primary illness. Consequently, they continue to try to alleviate the symptoms, not the illness.

Professionals who work with family violence, and who, with specialists in chemical dependence, are among the most progressive in acknowledging alcohol addiction as the primary illness, report that they must treat alcoholism before they work on the violence problems. Although alcoholism treatment doesn't cure abuse and incest, control of the addiction is a necessary prerequisite to the remediation of such problems.

Inappropriate/inadequate treatment for family members — Many practitioners and theorists maintain that families of those who are addicted to alcohol have a history of inadequate and/or inappropriate treatment.

One major obstacle to effective treatment is the persistent notion that people who marry alcoholics are either "mad" or "bad." A version of this view, called the "disturbed-person" theory or hypothesis, claims that women who marry alcoholics suffer from pre-existing personality disorders that make them toxic to the addict.

Some family theorists have expanded the theory suggesting that alcoholics drink to help a sick family — that alcoholism is an attempt to stabilize the family's pre-existing pathology. If we accept the premise that alcoholism is a primary illness, this position is equivalent to the argument that certain people develop diabetes to help sick family members.

Two 1982 surveys determined that treatment opportunities for children were available on such a small scale that they were virtually nonexistent. When treatment for the whole family was available, it was often conducted by someone who had no specialized training in family therapy.

Some chemical dependency treatment programs create additional conflicts for family members which are obstacles rather than aids to the family's recovery.

Some may use family members to create "a bridge to treatment" for the alcoholic.

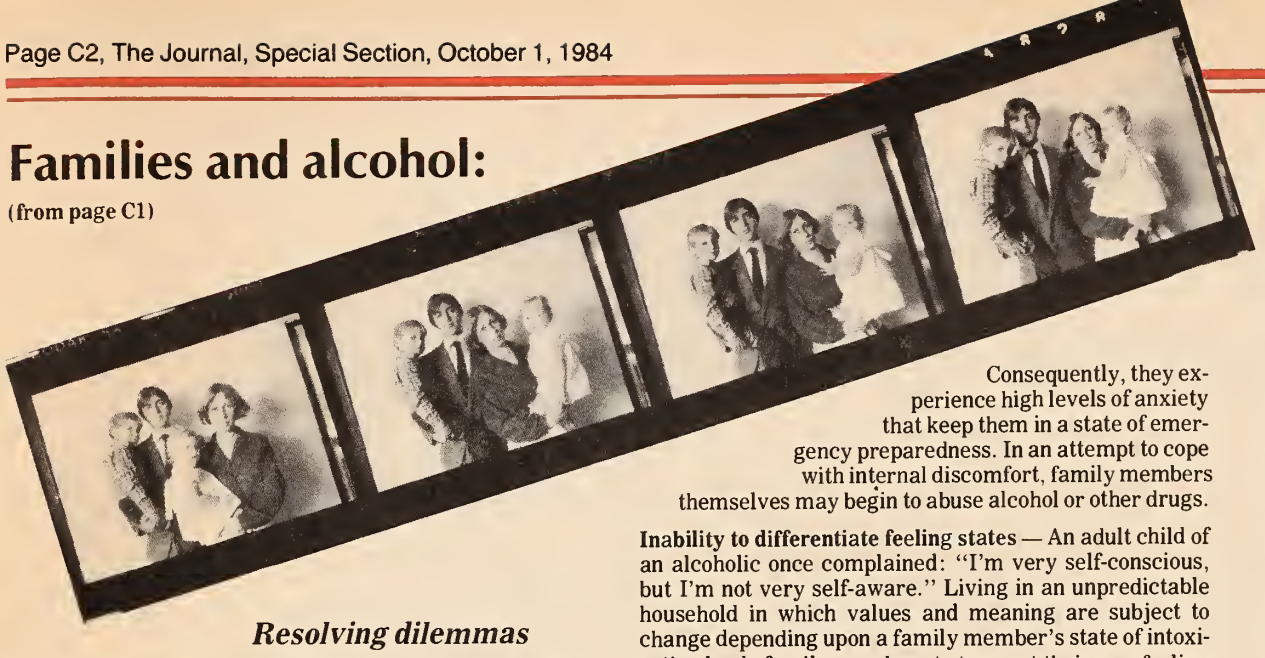
By emphasizing sobriety as the major goal of treatment, therapists may lead family members to assume that the family situation will improve as a direct result of a loved one's sobriety.

However, a parent who has ignored child-rearing responsibilities for many years, for example, will not acquire effective parenting skills automatically as a result of being free of alcohol. Clinical accounts indicate that newly-sober people both encounter and create problems when they re-enter their families.

By focusing solely on the alcohol addict, treatment programs may increase rather than reduce harmful symptomatology among family members. Family members usually suffer from the symptom of paying too much attention to the drinker and not enough attention to their own well-being. Treatment programs that merely require family members to attend alcohol education groups and Alcoholics Anonymous (AA) meetings may exacerbate that tendency. Treatment programs might arrive at a healthier balance by requiring the alcohol abuser to attend educational meetings on the problems of family members and Al-Anon meetings.

Families and alcohol:

(from page C1)



Consequently, they experience high levels of anxiety that keep them in a state of emergency preparedness. In an attempt to cope with internal discomfort, family members themselves may begin to abuse alcohol or other drugs.

Inability to differentiate feeling states — An adult child of an alcoholic once complained: "I'm very self-conscious, but I'm not very self-aware." Living in an unpredictable household in which values and meaning are subject to change depending upon a family member's state of intoxication leads family members to tune out their own feeling states.

The tendency to tune out feelings is probably related to the limited capacity for self-care and self-comfort exhibited by many individuals who live with alcoholics. Quite frequently, the limited capacity for appropriate self-care is hidden behind a facade of competence and overachievement.

Inability to resolve grief — Many individuals from alcoholic families appear unable to work through grief. They display the classic signs of someone caught up in a grieving process such as self-pity, anger, and resentment.

Adults who have long since left their families appear unable to grieve the parent they never had or the childhood they may have lost because they had to take care of parental responsibilities. Often such adults suffer from "block-outs" in that they are unable to remember much of their childhood. Block-outs only seem to bring family members more discomfort in that they prevent them from grieving and thereby freeing themselves from their losses.

Resolving dilemmas

At one end of the spectrum some health professionals argue that family members are essentially villains contributing to and even causing their loved one's addiction. At the other end of the spectrum, some argue that family members are victims of a family disease.

Some specialists even argue that the non-alcoholic's symptomatology represents a primary illness called co-dependency. By suggesting that family members are both victims of, and villains in, a pathological family, systems theorists approach the mid-range of the continuum.

Each of these vantage points is characterized by certain inconsistencies. By suggesting alcoholism is caused by malignant spouses or sick families, theorists ignore research findings which indicate that alcoholism is a disease characterized by risk factors which include, among others, genetic, environmental, cultural, and non-specific intrapersonal variables. Their view is also inconsistent with research results which demonstrate that the wives of alcoholics are no more disturbed than the rest of the population.

The co-dependency theory attributes all maladaptive behavioral patterns within an alcoholic family to the use of the addictive substance. Maladaptive behavioral patterns, however, may arise that are not related directly to chemical abuse.

The strongest criticism of the co-dependency theory comes from specialists within the alcohol field who insist that loving someone who is alcoholic is not in itself an indication of illness or disease.

The victim/villain approach may impair even further the limited sense of wholeness of people who already suffer from self-blame, low self-esteem, and feelings of guilt and anxiety.

Even though the view of the self as victim may be preferable to the view of the self as villain, such a view only seems to reinforce one of the family member's maladaptive coping strategies — ie, the tendency to focus on the addict rather than take responsibility for one's own well-being.

Both family members and professionals are in need of a model that will divert attention from the addict and place the focus on the specific needs of family members.

In this spirit, I recommend that we look at those who are, or who have been, attached emotionally to alcoholics, as survivors. Family members' greatest strengths are reflected in their attempts to cope with or survive the negative effects of loving someone with a chronic and progressive disease. They must learn to refocus this energy on themselves and to be responsible for their own well-being, regardless of whether the alcoholic recovers.

The Addiction Accommodation Syndrome, by which family members may arrive at a more compassionate understanding of themselves, postulates that those who live with chemical abuse, like those who live with child abuse, develop coping mechanisms that eventually become problematic in themselves.

Problems with object constancy — The capacity to maintain "object constancy" refers to the ability to maintain a stable feeling state toward another person. Both mates and children of alcoholics appear to have problems in this area. Children of alcoholics often see one parent as "all good" and the other parent as "all bad," or they may split along the wet/dry dimension and regard the intoxicated state, for example, as "all bad."

Although the mechanism of splitting may enable family members to adjust to the situation more easily, continued exposure to a loved one who is unpredictable and inconsistent has negative effects. Children grow up with a pervasive sense of insecurity and distrust, and have difficulty with intimacy and establishing on-going relationships.

Problems with a coherent and consistent sense of self — Those who live in an inconsistent and unpredictable environment for extended periods may lose or, in the case of children, never develop a coherent and consistent sense of self. Without a consistent sense of wholeness, individuals are vulnerable to fluctuations in self-esteem. Many of the spouses and children of alcoholics report they are "people pleasers," and that they look to other people or to external events to validate their sense of self-worth.

Rigid coping strategies — The experience of the self as vulnerable, as well as the need to ward off reality, leads family members to develop rigid defensive mechanisms. Woititz's statements that children of alcoholics take themselves too seriously and don't know how to have fun is one way of describing the family's rigidity. Family members' defensive strategies ultimately keep them from solving their problems, and individuals continue to be overtaxed.

Heirs of shame

By Cynthia Soyster, PhD

Soyster

A primary goal of the alcoholic family is to control the alcoholic's drinking. When attempts to control by begging, threatening, nagging, and restricting the supply of alcohol prove futile, the family experiences intense shame about its failure to achieve this goal.

This control by concealment becomes the family secret. It hides the alcoholism and the family's failure to control it both from public exposure and from acknowledgement within the family itself.

An adult child of an alcoholic reported: "In our family there were two very clear rules: The first was that there is nothing wrong here, and the second was, don't tell anyone."

The shame that encapsulates the alcoholic family is as profoundly and permanently damaging to its children as the disease itself is to the alcoholic.

Adult children report problems with trust, with expression of feelings, with gratification of needs, and with personal responsibility, all of which may be subsumed under one word — control. The most significant source of anxiety for adult children of alcoholics is conflict about the issue of control.

Shame is a normal affect, which has positive and growth-enhancing functions. However, for children of alcoholics, early traumatic shame experiences are exacerbated during subsequent development by the shame-dominated interactional style that characterizes the alcoholic family. Shame becomes a paralyzing affect which inhibits personal growth, interpersonal relationships, and initiative behavior.

Developmental considerations

A predisposition to shame may be laid down in the first 18 months of life, when stranger- and separation-anxiety signal the infant's disappointment and pain about his failure to control a wished-for, need-gratifying interaction with his mother.

In the alcoholic family, these early shame experiences are often traumatic, leaving the infant oversensitized to shame. For example, the mother in an alcoholic family is primarily attuned to alcohol; her emotional involvement with her baby is secondary. At times, she may fail to respond to her baby's cries; at other times, she may be overresponsive, smothering him with unwanted attention.

The family secret functions to protect, from the outside world, the family's failure to be in control. It also exerts tremendous pressure to keep attention, within the family itself, away from the failure. The alcoholic is never accurately labelled drunk. Instead, benign euphemisms such as angry, upset, or ill are used to describe the drunken behavior. A second denial strategy is the attribution of the drunken behavior to somebody other than the alcoholic. When a mother says to a child, "If you're a good girl, Daddy won't be angry," she is transmitting the unspoken message that the father's drinking is contingent on the girl's behavior. When the father continues to get drunk, the child believes that no matter how hard she tries, she can never be good enough to achieve her wished-for goal, and she is ashamed of her failure.

As the child matures, parental shaming becomes increasingly subtle and complex. An adolescent may be sent out into the world as a delegate of the parents, with the unconscious goal of redeeming her parents' failures by her own success, and of extricating them from their shame.

Indeed, the adult child of the alcoholic is apt to be highly educated and precocious in her career development.

Although she looks successful, she feels a failure, and lives in shame.

"I feel like my life is a hoax," said a successful professional woman. "I'm just waiting to be discovered to be the fraud I feel I am."

The family secret of concealment and shame provides a social and interpersonal model of behavior which the child emulates.

Driven by his/her own persisting omnipotence, the child relentlessly strives to achieve an impossible goal, only to experience repeated shame-producing failure. The only recourse is to fend people off, and to hide failures behind a brittle facade of control that is tenuously maintained by the defensive coping style associated with adult children of alcoholics.

Phenomenology of shame

In therapy, the adult child of an alcoholic often expresses shame through images that suggest she is becoming partially or completely invisible, or non-existent, and which also convey the panic, desperation, and urgency of the death threat that derives from early childhood. "I was so ashamed I could have died," is an expression that reveals the lethal implications of shame in everyday life.

Patients describe feeling singed, burned, or melted. Shame drowns people: "I felt like a kid thrown in the water when I didn't know how to swim." Shame jolts people; when asked a direct question, a patient said she felt put "on the hot seat," a thinly-veiled reference to being electrocuted. Patients report feeling "like the rug was yanked out from under me."

Criticism is felt as annihilation. Patients often use the word vulnerable to describe the aspect of shame that anticipates an imminent and uncontrollable trauma to the innermost private physical or psychological self. The psychic self is in danger of being exposed as being out of control, impotent, and a failure.

Images of being murdered, especially by stabbing, are common; rape images are reported by men and women. Shame is felt and visualized as being unexpected, unpredictable, shocking, excruciatingly painful, and out of control. Thus, it threatens one's very existence.

Therapeutic implications

A primary therapeutic task for adult children of alcoholics is to learn to specify the feeling of shame correctly.

Verbalizing feelings in the presence of another person, and recognizing the subsequent after-shock of feeling ashamed of one's shame, tend to mitigate the shame. Feedback provides new information that others experience similar feelings, which demystifies and attenuates the power of shame. When tolerance and acceptance of shame as a normal emotion has been accomplished, patients can find new meaning in the family secret and can better understand that they have internalized its unrealistic standards and goals as their own.

A second therapeutic task is to modulate the narcissistic goals which are internalizations of expectations embedded in the family secret, and to replace them with personal goals that are possible, realistic, and attainable.

It is important that the therapist help patients to identify, acknowledge, and confront the shame which is the legacy that alcoholic families leave to their adult children.

'In our family there were two very clear rules. The first was that there is nothing wrong here, and the second was, don't tell anyone.'

An adult child of an alcoholic

Concealment and contradiction

By Barbara Wood, PhD

Wood

Children of alcoholics defend themselves against the instability, aggression, and feelings of shame that seem to pervade their homes by adopting certain roles which bring some semblance of stability to the family and their own psychological experience, and to mask intense and painful emotions.

Wegscheider suggests that the most common childhood roles are the hero, the scapegoat, the lost child, and the mascot.

The hero is usually the first-born. When the scapegoat comes along later, he finds the family's limited capacity for enthusiasm and encouragement has been, more or less, fully expended upon the hero.

The scapegoat copes with his disappointment and sense of loss through rebellion, risk-taking, and, frequently, delinquency. At times, it seems as though only acts of destructiveness are capable of answering the emptiness of the scapegoat, or of helping him to reclaim a part of the limelight that the hero has usurped.

The lost child retreats from the world of interpersonal relationships into an inner world of fantasy and self-preoccupation.

The mascot is the "class clown," who, like the hero, seeks positive attention for himself and strives to produce a feeling of warmth and well-being in the strained family atmosphere. Wegscheider calls this child "a Pagliacci hiding his own pain behind a permanently painted grin."

Our understanding of children of alcoholics has rested upon our conception of these four childhood roles. More recently, the literature has reflected a concern with what happens when, as is so often true, the child in an alcoholic family remains untreated into adulthood.

It has been my observation that, while adult children of alcoholics will regularly enter into, and become lost in, the most difficult and punishing of situations and relationships, and will persist in their efforts to raise a phoenix from the ashes for what often seems an agonizing eternity, they are also capable of precipitous abandonment of these "projects."

Swings in behavior

These abandonments often have destructive consequences for the children and for others. I have come to think of these swings in behavior and mood as a shift in ego state — that is, as a transition from a mode that is dominated by the dutifulness and compassion of the hero to one in which the aggression of the scapegoat is ascendant.

One of my patients worked 60-hour weeks in her alcoholic mother's business, in order to complete her mother's work as well as her own. This behavior was designed to forestall customers' awareness of her mother's illness and the chronic mismanagement of the office that resulted from it. It caused the patient to neglect her own family responsibilities, as well as therapy appointments and university classes. At the same time, however, this patient was capable, when provoked, of taking three-week vacations without notice. Not infrequently, the vacations grew into the same alcoholic binges that my patient so deplored in her mother. The provocation for these "great escapes" was usually an act of alcohol-induced treachery committed either by the patient's mother or alcoholic boyfriend.

It has been my consistent experience that adult children of alcoholics are deeply and masochistically involved with their parents and siblings. One 26-year-old, who suffered severe allergies and whose father was alcoholic, said:

"The only place I've ever been able to breathe normally is in Arizona. I'd like to move there, but I feel I can't while my parents are still alive. My father, especially, depends on me to cheer him up."

The individual who grows up in an alcoholic family is a study in self-concealment, masochistic self-sacrifice, and, apparently, in contradictory extremes of behavior.

Where there is little sense of inner control and direction, there is also, frequently, an excessive, sometimes fanatical devotion to causes, beliefs, and leaders that seem to offer a possibility of focus and stability. This, of course, suggests the apparent loss of self experienced by adult children when they become so intensely involved with "lost" causes, or the effort to raise a phoenix from the ashes that I described above.

The literature tells us that a firm, integrated sense of self not only facilitates stable commitment to objects, but also increases the ability to tolerate difference and separateness from those we love and admire. The shaky, undifferentiated self cannot stand apart and retains a persistent, intense, emotional attachment to the family, focusing narrowly and obsessively on family needs, at the expense of personal well-being.

True spontaneity and individuality are lost as the child either allows itself to be absorbed by the needs of its troubled parents, or engages in a desperate and equally self-suffocating attempt to repel the onslaught by defining itself through total opposition to them.

Desperate efforts

If parents cannot respond to the child's need, and force the child constantly to react to and submit to their own needs, the child's ego will not undergo a natural unfolding and differentiation. Instead, it will become more or less a "collection of reactions" to the parents' failures. This collection of reactions, or "false self" abandons play and other carefree childish pursuits in a desperate effort to comply with the harsh conditions in the environment.

I believe the concept of the false self, as described by Winnicot, and the conditions that foster its emergence, can be applied to the alcoholic household. In such homes, the possibility of good-enough care is lost to a preoccupation with the pursuit and use of alcohol, as well as with the need to conceal, deny, and compensate for this fact. The alcoholic and his/her enabling spouse have little available energy to devote to an adaptation to the needs of small children.

Rather, the children are forced to adapt to a chaotic reality, and, very often, to nurture and support their parents when they are drunk or despairing or otherwise broken down. Thus, the children adopt false selves — the hero, the scapegoat, the lost child, or the mascot.

These false selves represent an attempt to deal with the parents' failure to parent; they both conceal and protect important aspects of inner reality. The false self is a largely unconscious device, and much as the active alcoholic remains deluded as to the dimensions and destructive impact of his/her drinking problem, the child of the alcoholic remains grossly unaware of many aspects of his/her inner experience, as well as his/her estrangement from it.

False selves are often unstable entities, and the self-sacrificing individual who wears the hero's mantle by day may display the scapegoat's bolder colors on other occasions, giving little doubt as to an underlying capacity for rebellion and aggression.

Another patient was the eldest child of an alcoholic mother and worked as a police officer. His most cherished role at work emphasized protection and rescue. He spent much of his free time working with troubled adolescents whom he had, in some cases, arrested. This individual, a genuinely dedicated and compassionate young man, was the subject of repeated brutality complaints, not only from people he arrested, but also from the nurses who treated these people in hospital. He never denied such charges, but defended his behavior as justifiable, and saw in it no contradiction to other aspects of his life.

Jacobson has related mood swings to an impairment of self that is the outcome of a failure of separation and individuation. She finds that a blurring of boundaries between the self and the parent results in an incomplete and damaged self that is subjectively experienced by the individual as helpless and as ever in need of the strength and protection of powerful, invulnerable, ideal objects.

Since no object (person, institution, or cause) is truly ideal and flawless, one can only answer such a need by attaching oneself to an imperfect object and elevating it to an ideal state through the use of illusion and denial, which, of course, are the defences of choice in the alcoholic family.

Adult children of alcoholics seem compelled to form these all-absorbing attachments with people almost certain to let them down.

When the disappointment does come, it may temporarily overwhelm the patient's capacity to deny the loved one's flaws. The patient will, at first, attempt to restore self-esteem by disparaging the loved object in a manner that is as illusory as was the original attempt to glorify it. The object will be disparaged (or, in the case of the young policeman, beaten) as the patient reactively identifies with the ideal, all-powerful image of the parent which has been threatened by the failure of the object. Such a response cannot continue for any lengthy period since this might ultimately lead to the complete destruction of the object which is so deeply and desperately needed.

Exaggeration of flaws

Thus, the patient will strive to restore the original configuration by shifting into a state in which there is a masochistic exaggeration of his own flaws and weaknesses, and in which he is once again subservient and inferior to the powerful object.

The pathological process may proceed so far that the patient becomes *too* depleted to restore the object; in this case, all he will be able to do is aggressively devalue the self *and* the object. The patient fails at this point to participate in the object's power and only wallows in its worthlessness.

This is the last phase of the illness, where the self-image of the patient merges with the deflated, worthless object image. It is at this point, I believe, that the hero becomes the scapegoat, or more precisely, shifts from an identification with the all-powerful parent whom he longed for as a child, to an identification with the disappointing parent he actually knew.

It is at this point too that my patients who are typically high-achieving family heroes will go on a binge, or abuse other drugs, as did their disappointing parents. They may become themselves neglectful or even abusive parents, if that is what they experienced as children, or sink into helpless despair, if that is what they witnessed in a parent.

All of this said, one may ask if there is any good news about children of alcoholics. I would say in response that much of the difficulty they encounter in separating from their troubled families stems from their deep capacity for attachment and love and their extraordinary ability to empathize with the suffering of their parents.

A cognitive-behavioral approach

By Leigh L. Thompson, MA, and Toni Zander, PhD

In the United States, 28 to 34 million people are raised in alcoholic homes. It is estimated that nearly 50% of these children will become alcoholics, and 30% will marry alcoholics.

The role a child adopts to survive in the alcoholic family becomes a pattern that is carried into adult life. While these roles are functional in that they allow the child to survive in the alcoholic home, they each create problems for the individual in later life.

A legacy of love and pain

Zander

Thompson

Even though children of alcoholics adopt different coping roles for survival, and develop specific problems later in life related to these roles, many of the current clinical treatments are general in nature, focusing on group treatment and facilitating expression of feelings. Other programs train children in coping skills.

The techniques used currently to treat children do not acknowledge their diverse roles and needs. The complex roles that these children adopt merit more specialized treatment approaches.

It is clear that not every child is affected by the alcoholic parent in the same way. However, traditional approaches often advocate only one behavioral sequence, which may not be therapeutic for all children.

Examination of the family structure and children's coping roles in the alcoholic home provide interesting clues to the difficulties these individuals often experience in adult life. In an environment where rules and expectations are unclear and inconsistent, a child has little opportunity to practise and model effective and systematic alternative coping behaviors. In fact, the child may learn only ineffective behaviors through modelling parental coping behavior.

A treatment approach designed to give children maximum choice, predictability, and control in their environment would appear to be most beneficial. A cognitive-behavioral approach stressing coping-skills training makes a variety of alternative responses available for the child. This serves to engender a self-concept that includes a sense of self-control or "learned resourcefulness" as contrasted with "learned helplessness."

The cognitive-behavioral approach bases treatment techniques on the different roles that children adopt in the alcoholic home.

It has two distinct advantages; it tailors techniques both to the specific needs of the child and to the role the child may adopt. The approach has applications for remediation as well as prevention of the problems of adult children of alcoholics.

The three methods discussed below are not intended as one-shot, isolated treatments. Rather, a developmental sequence is suggested, corresponding to children's skill attainment and as a more comprehensive view of the child's role in the alcoholic home is gained. For instance, self-instructional training, a basic and transferable skill, can provide the foundation for introducing attribution retraining, in which the child generates causal statements.

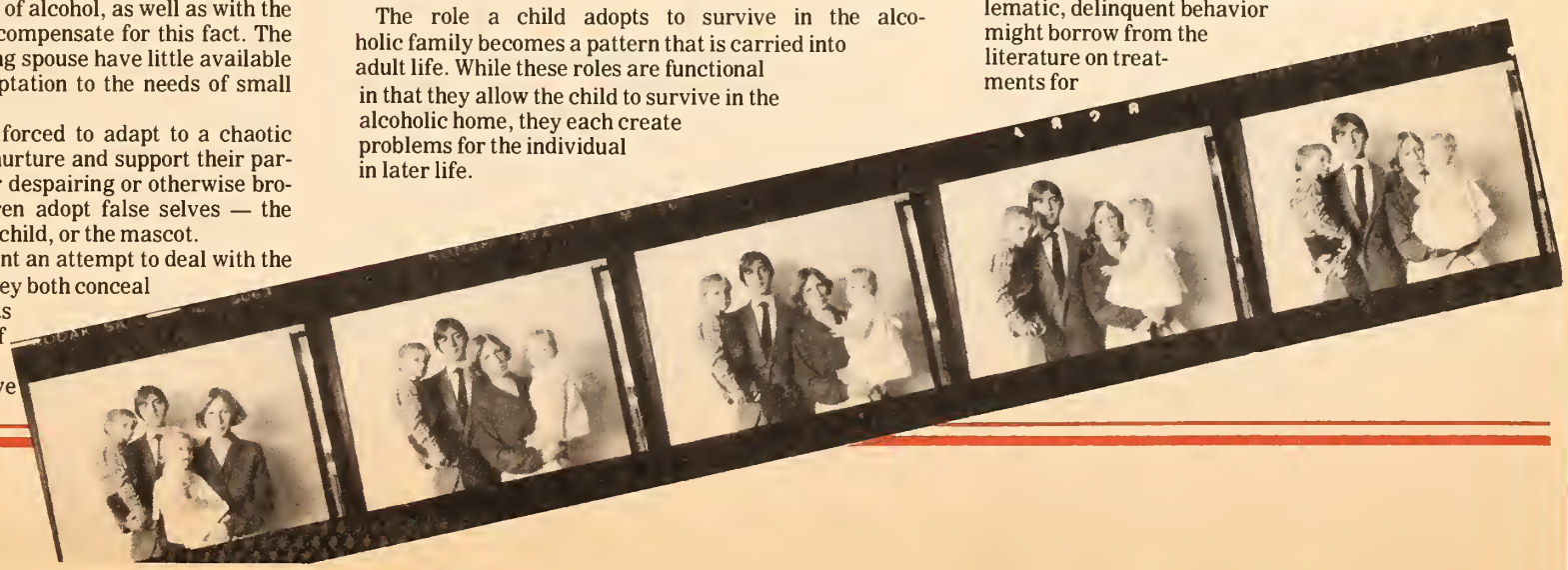
Stress inoculation training may follow identification of a child's causal attributions for specific, threatening events. Further, these approaches are suitable for both group and individual treatment. The approach stresses the importance of research into the processes through which children develop cognitive abilities to identify emotions and understand the behaviors and responses associated with their feelings. In essence, the cognitive-behavioral approach draws an important distinction between survival and effective coping.

Self-instructional training

Self-instructional training is an intervention technique in which children are trained to control their own behavior through "self-verbalizations." These are developed through a combination of procedures, including modelling, overt and covert rehearsal, prompts, and feedback. Well-suited to children, it provides them with a form of self-control, parallels or enhances their cognitive development, and provides a general coping skill rather than a situation-specific response. It has been used with impulsive children , hyperactive and aggressive children, and those with academic behavior problems.

In children of alcoholics, it would provide direct experience in relying upon internal speech, often ignored in the alcoholic family, and give them more experience with self-expression, which is usually denied in the alcoholic home. Finally, they would experience a clear contingency between words and behaviors, which would serve to increase their sense of control and predictability.

Treatment plans for the acting-out (scapegoat) child who engages in problematic, delinquent behavior might borrow from the literature on treatments for



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aggressive children. Some specific applications include modelling non-aggressive peers, relaxation training as an incompatible response, alternative thinking and decision-making, and perspective-taking training.

The responsible child (the family hero), who tends to perform a rigid and structured role, could be trained in role-playing new and varied roles, play therapy, and cooperative games. Cooperative tasks would enable the child to learn to depend on others and recognize his or her own limits of control.

The placating child (the family mascot), who often does not recognize his own needs and feelings and frequently experiences guilt, may be trained in an approach which would help him recognize feelings in himself and others. This approach teaches children to express a variety of emotions; games, roleplays, cartoons, and stories emphasize that all feelings are a normal part of life.

Finally, the adjusting (lost) child, who tends to adapt passively to situations rather than initiate them, may be trained in initiating interactions. This includes wanting to initiate an interaction; worrying about negative consequences, self-debate, deciding to try; and approaching, greeting, and stating a request.

Attribution retraining

The basic assumption of attribution theory is that humans seek and ascribe causal forces to explain events and that these attributions may exert a strong influence on behavior.

Attribution retraining teaches individuals to generate or assign specific attributions for events and outcomes through various techniques.

Many children of alcoholics struggle with issues of control and self-worth in adult life. The root of this potential "helpless" orientation may be grounded in the role the child adopts in the alcoholic home. The pervasive unpredictability of events may lead to the development of learned helplessness in the child. A child who is subject to inconsistent, unpredictable environmental demands could easily develop an external orientation.

In other children, the alcoholic home may foster an overwhelming sense of personal causation and responsibility. The possible maladaptive behaviors correlated with an extreme internal locus of control should not be overlooked.

Based on knowledge of a child's pattern of coping in the alcoholic home, therapists may design retraining procedures to the specific needs of the child, with an eye to the potential future problems associated with these roles.

The responsible child may be trained to attribute negative events to external forces, thus de-emphasizing the need to control.

The adjuster may be instructed to attribute negative events to variable, internal forces. This attributional orientation would necessitate control.

The placater may be trained to attribute negative outcomes to variable factors and positive outcomes to internal factors. Such an attributional framework would be incompatible with feelings of guilt.

The acting-out child may be trained to attribute negative outcomes to variable, external factors, perhaps removing the need to exert control in self-defeating ways.

Stress inoculation training

Stress inoculation training provides individuals with a prospective defence or set of skills to cope with future stressful situations. Further, incorporation of potential threatening events into cognitive plans tends to reduce anxiety and lead to more adaptive coping strategies.

Stress inoculation training may prove to be a valuable technique in treating children of alcoholics. Children can practice cognitive coping skills before the stressor occurs. Further, in rehearsing these skills and preparing for the stressor, children are in a better position to predict the onset of a stressful situation, which may lead to increased control over situations.

Specifically, responsible children could employ stress inoculation when they feel a need to assume control in situations that in fact preclude control.

Adjusting children may engage in stress inoculation when they confront conflicting demands and when situations do not permit mere adjustment.

Placating children could practise stress inoculation during family upsets and emotional situations.

Finally, acting-out children may employ stress inoculation techniques when angered or aroused.

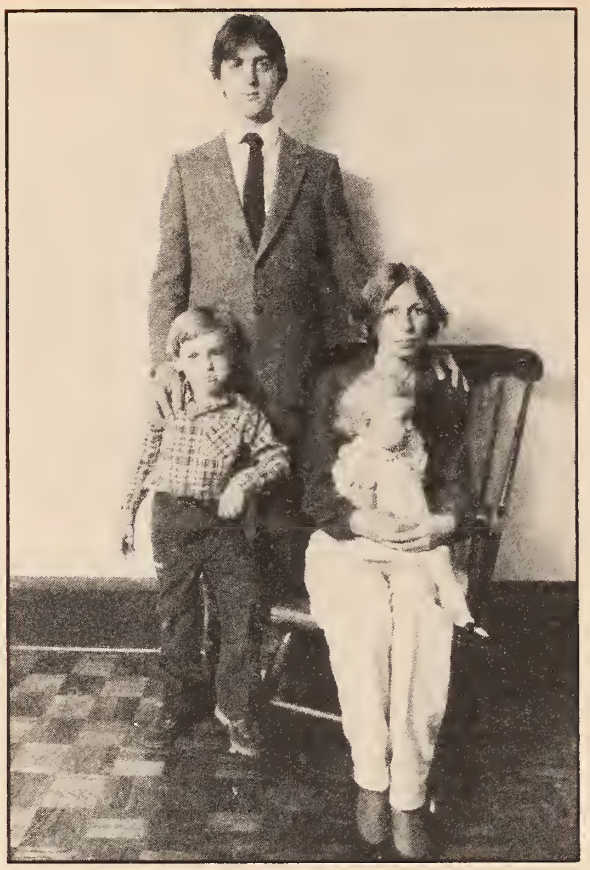
A structured group model

By Thomas Perrin, MA


Perrin

Our first group for adult children of alcoholics started in a private setting in 1982 with Carolyn Kleinman, MA, and myself as co-facilitators. Subsequently, we have initiated several groups and have seen more than 100 adult children of alcoholics in groups ranging in duration from four, weekly, two-hour sessions to therapy groups meeting weekly over a year-and-a-half.

Our group members have been predominantly female, in a ratio of nine or 10 to 1. Our male workshop members have benefited by their exposure to a female majority, enhancing their sensitivity to feminist issues and providing women with alternative role models. The single largest occupational group has been nurses. The second greatest has been computer programmers. Our groups have been composed equally of people who claimed they were non-alcoholics, and recovered alcoholics. Of the recovered, all had six or more months of sobriety, which we would recommend as a minimum. At least one workshop participant has been motivated to join AA to deal with her own drinking as a direct result of her workshop experience.



These groups had their primary origin in my own search for understanding of what I had experienced in my own family of origin. My mother is addicted to alcohol and pharmaceutical drugs. My father and siblings are alcoholic. I am alcoholic.

The facilitators, in private practice in alcoholism counselling, had received inquiries for assistance from adult children of alcoholics who had sought, and not received, help from the traditional alcoholism self-help groups. AA necessarily limits its active assistance to people who have a desire not to consume alcohol. Al-Anon was not able to create an environment in which the adult child could readily identify.

We initially drew our group participants from the clients of other therapists. Many group participants were motivated to attend workshops after reading, and identifying with, a list of characteristics of adult children of alcoholics.

Anguish and pain

The personal histories of our clients reveal much anguish, alienation, and pain arising out of their families. Rejection, abandonment, and outright betrayal continue to dominate the lives of our clients. For some, the message was very clear: they were not loved. For others, the message was ambiguous: rejection one day and love the next.

When our culture decrees that the consumption of alcohol by the alcoholic is willful and morally wrong, the alcoholic's child receives the message that the wrongs that are done to him are done willfully and with malice. This is a situation which invites feelings of betrayal and abandonment, often followed by rage and hate. When these feelings are not resolved in childhood, but are instead integrated into the *persona*, the effects reach far into adulthood. Feelings of hate which were once directed against one's parents may, in adulthood, be directed at the self.

If the child does not perceive the cultural message that the alcoholic's consumption of alcohol is morally wrong, he is nevertheless faced with the necessity of resolving the discrepancy between his own love for his parents and the loss of the love which should have been received. To resolve this conflict, he may identify with the alcoholic parent's behavior in the same manner that the prisoner of war will identify with a brutal camp guard. Since it is inconceivable that his parent could not love him, the only conclusion is that the child alone is responsible. The rejecting actions of the parent were deserved or caused by the child.

On the other hand, if the child understands that the parent is powerless over alcohol and did not choose to become an alcoholic and that the loss of love, bonding, and kinship in the family are due to the intervention of the chemical alcohol, quite different conclusions are drawn by the child. Alcoholism is relegated to the same status as any other chronic, debilitating disease. The traumas which occur in the family no longer need to be taken personally. The child no longer has a need to hate, to feel betrayed and abandoned. These feelings are replaced by those of hurt (because alcoholism in any form hurts). Sadness and grief over the loss of what could have been, had alcoholism not been present, need to be worked through.

Concurrently, when the child becomes able to understand that the wrongs that are done by the alcoholic are associated with the consumption of alcohol or withdrawal from it, the child is often able to forgive the parent and himself. More difficult, more complex for the child, is the understanding that the non-alcoholic's rejecting behavior is as much a product of alcoholism as the alcoholic's behavior is a sequel to drinking.

Abandoning blame

Implicit in the conduct of the workshop group is the idea that to achieve growth, blame must be abandoned. Although hurt and anger must be acknowledged, felt, and accepted, blame destroys the possibility of resolution. Children of alcoholics have too long been impaled on a picket fence of "should have beens" and "if only's." They are, instead, invited to take part in the discovery of their own talents, to build their self-esteem, and to take responsibility for the repair of any damage done by the alcoholism in the family.

As the facilitator of self-help groups for adolescent children of alcoholics for a three-year period prior to the formation of groups for adult children, I had perceived that group members confused sex, touching, intimacy, and love, with sex most often taking the place of the other three.

To stimulate discussion of this confusion, a lesson on touching was added to the agenda.

The description in the agenda simply reads: "Touching: an exercise in intimacy." Of all items on our agenda, this one provokes the most anxiety.

For the large portion of our population which has been physically or sexually abused or assaulted, it is a chance to begin recovery with the simplest of sensate focus exercises.

Our group members are directed to hold hands with a person of their choice during the next week and to concentrate on the feelings which arise out of skin contact. The following week, the exercise is processed in group. For most, it is a novel and enlightening experience.

It is our general impression that children of alcoholics are deprived of the experience and knowledge of benevolent skin contact from a very early age.

Parenthetically, we note that the minor children of alcoholics who are hyperactive benefit from touch (massage of the back, hand on stomach) by the therapist and from the teaching of touch to the parents. We strongly suggest that this method should be tried before attempting to prescribe mood-altering drugs. Our hypothesis is that hyperactivity in the alcoholic family is a symption of anxiety and skin hunger and is better treated through treatment for alcoholism than by the administration of a tranquillizer, Ritalin, or some other drug.

Continuing support

Having opened up so many doors for our workshop participants, we feel it necessary to offer many forms of closure. Closure begins in the first session with a discussion of the purpose and management of flashbacks. Our last meeting is devoted solely to closure issues. Participation in other forms of therapy, such as individual, group, and family counselling, is encouraged. We strongly suggest seeking continuing support in one or more of the alcoholism self-help groups. The rapid growth of self-help groups composed solely of adult children of alcoholics permits choices of quality and location. Many of our workshop participants have continued in longer-term groups of adult children of alcoholics where interpersonal issues can be effectively worked upon.

In sum, then, adult children of alcoholics need to be loved by both parents; experience a progressive weakening of bonding by both parents; experience and perceive loss of love by both parents; internalize feelings of rejection and hate, including self-hate and self-rejection; and, continue to possess a need to love both parents.

I suggest that the adult child's unremitting search for answers to questions which have never been formulated benefits from asking new questions about the effects of alcoholism on the family and the child's role in that family.

The speakers

Sarah **A. Reagan**, PhD, private practice, Alexandria, Virginia.
"Alcoholic Family: The Disease and Its Dilemma"

Cynthia Soyster, PhD, Stanford University Medical Centre and in private practice, San Francisco, California.
"Adult Children of Alcoholics: Heirs of Shame."

Barbara L. Wood, PhD, private practice, Silver Spring, Maryland.
"Children of Alcoholics: Patterns of Dysfunction in Adult Life."

Toni A. Zander, PhD, visiting assistant professor, Counselling Psychiatry program, School of Education, University of California, Santa Barbara; and **Leigh Lassiter Thompson**, MA, Dept of Psychology, Northwestern University, Evanston, Illinois
"Treating Children of Alcoholics: A Cognitive-Behavioral Approach"

Thomas W. Perrin, MA, family alcoholism counsellor and consultant, Rutherford, New Jersey.
"Psychotherapy with Adult Children of Alcoholics: A Structured Group Model"

Bibliographies of the papers excerpted here and presented at the American Psychological Association annual meeting are available from The Journal, *33 Russell St, Toronto, Canada M5S 2S1.*

NEWS

Addiction is major factor in physician suicides

By Betty Lou Lee

EDMONTON — Addiction to alcohol or other drugs is a major factor in suicides by doctors, says Saul Cohen, MD, chairman of the Alcoholism Commission of Saskatchewan.

One per cent of physicians become addicted to narcotics, and 10% of those will commit suicide.

While this is double the rate of narcotic addiction in the general population, their rate of alcoholism is about the same — 7% to 16%, he told the annual meeting of the Canadian Medical Association (CMA). The CMA set aside a half-day of its three-day scientific meeting here to the high-risk and impaired physician.

"The causal factors of suicide are drug addiction and depression associated with financial and practice difficulties."

While male doctors have about the same suicide rate as other age-matched men, the rate for female doctors is three to four times greater than for other women. The women are more likely to kill themselves during medical training, the men between ages 45 and 65.

"More physicians die as a result of alcoholism and drug addiction than from accidents and homicides," Dr Cohen said, and they represent "a very talented group of the profession." Fifty-four per cent of addicted doctors were in the upper third of their graduating class.

He said it is "hard to document" how much addiction affects patient care, and can recall only a few cases reported to medical authorities in Saskatchewan. Dr Cohen served as a member of that province's Physicians at Risk Committee when it was the first one formed in Canada, in 1976.

But, at a later press conference, when it was suggested breath tests outside operating rooms, and periodic blood or urine screens might be advantageous, he said: "It's something society should have a look at, checking out from time to time when people don't know it's going to happen."

He was quick to add he would like to see the same thing for airline pilots and crane operators in industry.

Dr Cohen said medical schools have a role to play in earlier identification of high-risk individuals, and applicants should be "looked at from all angles, with a close evaluation of social and family history — not to reject them, but to identify who could be at high risk.

"Lifestyle retraining programs, where they learn to lean on people rather than pills," could be recommended to them.

Alcohol is not sufficiently recognized as a drug in medical schools, and students don't learn enough about it for their own, or their future patients' use, he said.

"Those who get loaded once or twice a week present a macho image to their peers. They're saying, 'We're a select group who can take drugs and drink without harm because we have the knowledge.' "

Dr Cohen said four factors make it difficult for doctors to seek help with an addiction problem: it's hard for them to accept the fact they need help; they often don't know where to find it; it's hard for them to accept a patient role; and those who are self-employed lose their income when they go into treatment.

LeRoy le Riche, MD registrar of the College of Physicians and Surgeons of Alberta, said, "to look into the cause of the disease does damn all to the treatment. There will always be stress, difficulties with spouses, and doctors will always be called up at night."

He favored intervention and confrontation once sufficient evidence of a problem is documented.

"You have to treat without informed consent, act with dictatorial authority. He'll often accept it, even though you don't have it under the law . . . I know if something isn't done, the doctor will die: it is a lethal disease, and he can't go it alone," said Dr le Riche.

Joseph MacMillan, staff physician at The Donwood Institute, Toronto, said the Ontario program that began in 1977 now includes registered nurses, other health professionals such as dentists and pharmacists, and spouses of patients.

Of the first 200 doctors, 12 were on welfare, and a pediatrician had been working for three years on construction jobs. The Ontario Medical Association now makes interest-free loans available for those in treatment, and the 30 loans approved have either been, or are being, paid back.

Two Toronto-area hospitals also have a program whereby a recovering doctor can scrub as second assistant in the operating room. Not only can he make some money, but he can "develop quiet re-entry into the atmosphere of a hospital and into medical life and not be emotionally or legally responsible for patient care." Four doctors have done well in this program.

Cohen: leaning on people not pills

In the past two years, 115 doctors in the community have volunteered as "physician advocates" to provide a "friendly, accessible ear" to addicted doctors who have just finished the residential treatment program. In the past year, this group has also referred 15 more doctors to the treatment program.

Dr MacMillan said all health professional addicts share "an incredible knowledge of drugs . . . covering all the synergisms, antagonisms, actions, and reactions," and this knowledge subtly confers permission to self-medicate.

"It is okay to give some erythromycin (an antibiotic) to your five-year-old son for his tonsillitis . . . and it's okay to use a small amount of Demerol (pethidine) for your back-ache in order to keep up with your appointment schedule.

"Almost no physician has a primary-care physician, and if he does, he magically migrates to one who either sees alcoholism as a Valium (diazepam) deficiency or who, like so many physicians, cannot see chemical use as a problem. You have to be using more than your doctor before he will see it as a problem.

"If the troubled physician does risk going to a doctor, the odds are high that he will not be treated as a patient, but rather with some avuncular advice which will prove correct his original assumption — that he is the best physician available."

Herbal medicines need study as treatment tool for drug addicts

By Lachlan MacQuarrie

HONG KONG — Non-opiate Chinese herbal medicines could prove as effective in narcotics treatment as Western medicine and much less expensive, predicts Mabel M.P. Yang, of the Hong Kong University Faculty of Medicine.

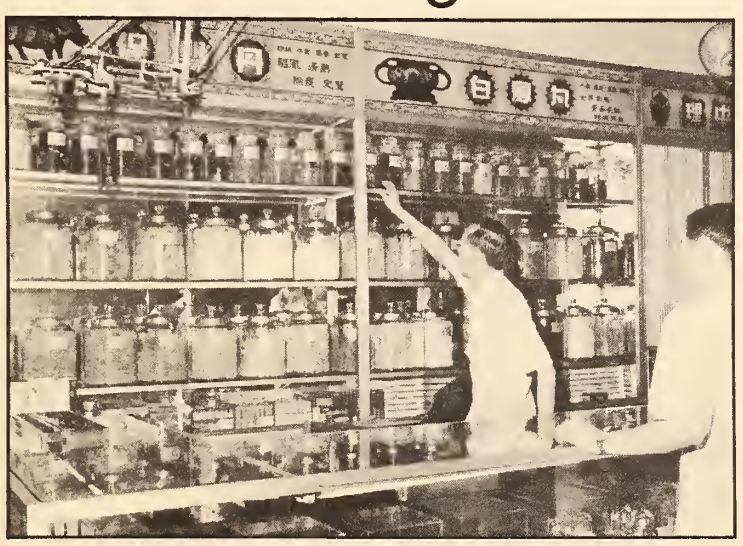
Dr Yang told the 2nd Pan Pacific Conference on Drugs and Alcohol here that the use of Chinese herbal medicines in narcotics treatment dates back at least to the time of the Opium Wars in the mid-1870s and they are still being used in many Asian countries.

A program of herbal treatment operated in Buddhist monastaries in Thailand has reported abstinence rates of 30% in heroin users and 60% in opium users six months after treatment.

Malaysia has recently become one of the countries participating in World Health Organization trials for evaluating traditional medicines, and reports on treatment programs being monitored to date show abstinence rates of 8% to 35% after a one-year observation period.

In Hong Kong, Dr Yang found herbalists extremely reluctant to reveal the exact content of their medicines used in traditional treatment, but she identified some as turmeric leaf, the creeping herb *Hydrocotyl asiatica*, leaves of the white hibiscus tree, lalang grass, ginger root, *Mimosa pudica*, and the mengkuda fruit.

Usually, several of these herbs are prescribed together in differing combinations. They are brewed together to form a "tea" to be taken by the patient.



Chinese herbalists: reluctant to reveal the content of medicines

Dr Yang examined the records of a Chinese traditional medicine clinic which had treated nearly 300 cases of drug addiction by herbal medicine in the past five years, claiming significant "success" rates.

She also interviewed some patients after only one week of treatment and "observed that the withdrawal symptoms were suppressed about 10 minutes after taking the tea and this effect lasted for a few hours."

Some of the patients told her that during the treatment they could not take opium or heroin because they suffered nausea and vomiting.

Dr Yang also interviewed some cured patients one to three years after treatment. Most of these patients told Dr Yang that they thought Chinese herbal treatment was better than both the acupuncture and the methadone treatment available in Hong Kong because these two methods suppressed only "the withdrawal symptoms but not the craving for drugs."

Dr Yang also investigated the effects of some of the Chinese herbs on experimental animals, particularly with respect to analgesic properties of the herbs and their efficiency in reducing morphine withdrawal symptoms. "These studies," said Dr Yang, "suggest that herbal medicine, a non-opiate treatment, could be an alternative prescription.

"There is clearly a need for further, careful description of traditional methods as produced in the region, together with stringent evaluation of their success rates," said Dr Yang.

"We all know that treatment of drug addiction is not a field with high success rates. Thus, if traditional methods of treatment are found to have at least equivalent success rates, then there may be, at the very least, an economic argument for using the cheaper methods as part of our national addiction treatment programs. We may even miss an important source of treatment if we ignore local traditional medicines in favor of exclusive use of internationally used practices," said Dr Yang.

MDs prescribe more taxes to discourage tobacco use

By Betty Lou Lee

EDMONTON — Canadian doctors are calling for higher taxes on tobacco to discourage its use, and for the extra revenue to be earmarked for health budgets "commensurate with the social cost of tobacco-related illness."

It was one of six tobacco-related measures recommended by the general council of the Canadian Medical Association at its annual meeting here.

"We must take a high profile. Smoking is the single most preventable cause of illness," said Gerald W. Karr, MD, of Penticton, British Columbia, who proposed the measures.

Doctors want legislation to prevent smoking in government buildings, particularly hospitals and other buildings where health services are provided, and incentives to control smoking in private buildings, especially workplaces.

They called for legislation to prevent tobacco advertising in conjunction with athletic events, and government incentives for more education programs directed at smoking prevention in the schools and smoking cessation in the whole population.

Tobacco farmers, they said, should be encouraged to switch to alternate crops, or assisted in retraining for new jobs, again through government incentives.

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BAL testing biases may foil accurate crash data

By Harvey McConnell

SANTA FE, N Mex — A number of biases about administering blood alcohol level (BAL) tests at the scene of fatal automobile accidents may underestimate the rate of alcohol involvement.

This has emerged from a study by the United States National Institute on Alcohol Abuse and Alcoholism (NIAAA) and a Washington contract firm which operates the Alcohol Epidemiologic Data System (AEDS) based on information supplied by the states.

Researchers searched for differences in types of people and situations in which BAL tests are likely to be given. Henry Malin, acting chief of the surveillance branch, NIAAA, Kathleen Jablonski, PhD, a former AEDS research analyst, and colleagues did the study and reported it to the 2nd Congress of the International Society for Biomedical Research on Alcoholism meeting here.

Data from eight states were found to fit the criteria set by the researchers in looking at fatal accidents in which blood alcohol tests were administered, compared with fatal accidents in which they were not administered.

A number of factors, including age, race, sex, type of vehicle driven, and number of people in the vehicle were examined to see if there was a variation in the frequency of blood alcohol concentration tests. Among the findings:

- Male drivers are given blood alcohol concentration tests more often than female drivers.
- Young male drivers are tested more frequently than older male drivers.
- Testing for female drivers depends less on age than it does for male drivers.
- There may be an under-representation of female drivers who were drinking when they were involved in fatal accidents.
- There may be an under-representation of the number of older drivers who were drinking at the time of their accident.
- Drivers are tested more often than passengers. Those injured or killed are tested more often than those not injured.

The findings lead the researchers to the conclusion that biases exist in determining who will be administered a blood alcohol concentration test, and such biases may result in an under-estimation of alcohol involvement in fatal crashes. Thus, policy decisions concerning the drinking driver may be based on biased data.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000 ext 7384.

The Party's Over

Number: 621.
Subject heading: Alcohol and youth, drugs and youth.
Details: 21 min, color, video.
Synopsis: Two girls are having a party in their apartment. They are planning to get "high" and hope that one "straight" friend does not spoil the party. As their friends arrive, they all begin to drink and smoke marijuana. One of them, Paul, tries to persuade his girlfriend not to use any of the drugs, but Louis, the pusher, convinces her to try drugs. While the others dance, smoke marijuana, drink, talk, and argue, Louis gives the girl what is assumed (by the viewers) to be cocaine. As a consequence, she has trouble focusing and talking, and passes out on the kitchen floor. The other people at the party physically attack Louis.
General evaluation: Poor to very poor (1.9). The assessment group believed the portrayal of the party was unrealistic for the majority of Canadian youth. Therefore, the tape was judged not to be a good educational tool.
Recommended use: Could be used as a discussion starter with audiences aged 15 to 18 years.

Cocaine Blues

Number: 620.
Subject heading: Cocaine.
Details: 28 min, color, 16 mm.
Synopsis: All aspects of the use and abuse of cocaine are shown. Users talk about their experiences; pushers point out how profitable it is to deal in cocaine; drug enforcement officers show to what lengths they go to seize the drug; treatment people talk about what they have seen in clinics; and researchers describe how the drug seems to affect the user.
General evaluation: Fair (3.0). This fast-paced film tried to cover all aspects of heavy cocaine use. Its anti-cocaine message was clearly stated.
Recommended use: Adult audiences with a resource person.

Children of Alcohol

Number: 622.
Subject heading: Alcohol and the family.
Details: 18 min, color.
Synopsis: Alcoholism is a problem that touches every member of a family. Children from homes where there is an alcohol problem blame themselves, feel depressed, frightened, and generally have problems coping. The Alberta Alcoholism and Drug Abuse Commission is trying to assist these children. They help the children raise money to participate in a horseback camping trip into the mountains. While camping, group sessions are held in which the young people can express feelings and learn to deal with their situations.

General evaluation: Very good to excellent (5.5). This contemporary, well-produced film had great emotional impact. The setting and reactions of the young people during the group sessions make this a good teaching aid. General broadcast was recommended.

Recommended use: With a resource person, this film would benefit general audiences and, especially, parents and young people from homes where alcohol is a problem.

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NEWS AND DEPARTMENT

Five-year plan targets educators, politicians

WHO program aiming to sober up Europe

By Thomas Land

GENEVA — Alarmed by the rapid rise of alcoholism in Europe, the United Nations' World Health Organization (WHO) has launched a five-year program of scientific analysis, health education, and political persuasion to sober up the continent.

The project was endorsed by the WHO's European Advisory Committee for Medical Research at a meeting in Copenhagen. It criticized the continent's "weak, fragmented, and often contradictory national policies . . . to combat alcohol abuse in most countries" where "profits from the sale of alcohol often lead to conflict between economic interests and health preoccupations."

Per capita consumption has risen by more than 300% in some European countries since 1950. The WHO specialists also noted a disturbing trend toward heavier drinking among women and the young. Indeed, in many countries, an estimated 80% of 15 year olds were found to be regular drinkers.

Golobitsh

European drinkers: per capita consumption up 300% since 1950

The European campaign will be part of a global program coordinated by the Geneva-based WHO and intended to alert health professionals, administrators, teachers, legislators, and opinion makers to the devastating spread of alcohol problems.

Liver cirrhosis now ranks among the leading causes of death worldwide. People diagnosed as alcoholic occupy up to half of all beds in general and psychiatric hospitals. Drivers with measurable blood-alcohol levels account for perhaps half the road fatalities.

Jan Ording, program coordinator, explained in a recent issue of the WHO journal, *World Health:* "We are working to develop a methodology to deal with alcohol-related problems, to establish techniques for studying communities dealing with their own alcohol problems, and to provide guidelines for investigating alcohol problems . . ."

The campaign will bring together the knowledge and skills of many outside experts.

Research at community levels will involve many universities and will examine ways of reducing the physical, mental, and social stresses present in families in which one or more members drink excessively.

Alcohol problems in industry will be considered with help from the UN's International Labour Organization.

An analysis of the international alcohol production, marketing, and distribution business, and its effects on global health standards, will be compiled in collaboration with the UN Conference on Trade and Development.

The WHO has also invited working papers from experts on such topics as relevant international trade agreements and the interrelationship between alcohol consumption and the tourist trade.

Pilot marketing and consumption studies have been launched already in countries like Britain, Zambia, and Mexico. They are to elaborate the findings of a recent global study showing that alcohol consumption has increased most in the developing countries where Western commercial products have, as a rule, replaced the traditionally less potent local brew.

The WHO's regional program for Europe will begin with an analysis of the national policies of the region. The organization has already started a study on the special problems arising from alcohol abuse by young people.

The Copenhagen meeting was preceded by a symposium here in Geneva of doctors, economists, sociologists, and others concerned with the public health aspects of the alcohol industry. The symposium called for radical changes in alcohol control throughout Europe. The campaign will seek to bring them into force.

New Books

by RON HALL

A School Answers Back: Responding to Student Drug Use

. . . by Richard A. Hawley

This book is intended for school staff, parents, and others interested in confronting and reversing the use of drugs by children. The first section is intended to serve as a blueprint for schools that wish to start a drug program or that wish to augment what has already been started. The second section recounts the author's experience at a school, which he hopes will be useful to other schools. Several assumptions are made explicit at the beginning of the book. The first is that there are no important distinctions among the various drugs as to which is more dangerous. Another assumption is that the prevention of student drug use will succeed only if the school, with the support of the community, is aiming to become drug free. The chapters cover epidemiological aspects; training staff to recognize and respond to student drug use; referral to treatment; starting a parent awareness network; understanding student drug use; and responding to student drug use.

(American Council for Drug Education, 6193 Executive Blvd, Rockville, MD 20852, 1984. 146 p. $5. ISBN 0-942348-14-1)

Other books

The Alcoholism Treatment Program at Canadian National Railways: A Case Study — Groeneveld, Judith; Shain, Martin; Brayshaw, Donald; and Heideman, Isabel. Addiction Research Foundation, Toronto, 1984. Policy development and implementation; management of alcohol-dependent employees in the work environment; program evaluation; recommendations. 99 p. Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1. $7.50. ISBN 0-88868-092-9.

Drug Abuse: Foundation for a Psychosocial Approach — Eiseman, Seymour; Wingard, Joseph A.; and Huba, George J. (eds). Baywood Publishing, Farmingdale, 1984. Applications of a theory of drug use to prevention programs; constructive peer relationships, social development and cooperative learning experiences; an approach to primary prevention of drug abuse among children and youth; education about narcotics and dangerous drugs; drug education; alcohol use and self-esteem of adolescents; patterns of drug use among Mexican-American potential school dropouts; films and drug education; cross-cultural field study of drug rehabilitation; issues in the training of alcoholism counsellors; drug program evaluation. 268 p. Baywood Publishing, 120 Marine St, Farmingdale, NY 11735. $16.75. ISBN 0-89503-039-X.

Preventing Adolescent Drug Abuse: Intervention Strategies — Glynn, Thomas J., Leukefeld, Carl G., and Ludford, Jacqueline P. (eds). National Institute on Drug Abuse, Rockville, 1983. NIDA Research Monograph 47; role of mass media in preventing adolescent substance abuse; social-psychological approaches; prevention through adolescent health promotion; comprehensive community programs; prevention through the development of personal and social competence; alternatives to drug abuse; family-based approaches to adolescent substance abuse; prevention through social skill development; drug education. 261 p. US Government Printing Office, Washington, DC 20402.

The Addictive Behaviors — Shaffer, Howard, and Stimmel, Barry (eds). Haworth Press, New York, 1983. History and social ecology of addictive behaviors; biological assessment of addiction; diagnosis in the addictions; causal factors in onset of adolescents' cigarette smoking; caffeine; methadone maintenance; clinical implications of models of recovery for alcoholism; controlled opiate use; addiction relapse. 172 p. Haworth Press, 28 E 22 St, New York, NY 10010. $22.95. ISBN 0-86656-243-5.

Drug Trade and Drug Use — Wardlaw, Grant (ed). Australian Foundation on Alcoholism and Drug Dependence, Canberra, 1982. Proceedings of the conference presented by the Australian National University on Drug Trade and Drug Use held in Canberra, October 22 to 24, 1980; government policy on drugs and drug-related problems; strategy for drug abuse prevention; youth drug use, social expectations, schooling, and the drug problem; prescription drugs; political and economic features of the drug trade; drug use and crime; patterns of drug use; impact on a hospital of alcohol and drug related problems; role conflict for the pharmacy in the drug market. 123 p. Australian National University Press, PO Box C831, Rutherford, NJ 07080. $12. ISBN 0-909190-16-X.

Measurement in the Analysis and Treatment of Smoking Behavior — Grabowski, John and Bell, Cathrine S. (eds). US Government Printing Office, Washington, 1983. NIDA Research Monograph No 48; overview of issues; use of biologic fluid samples in assessing tobacco smoke consumption; measurement issues in cigarette smoking research; analysis of reinforcement by varying smoke component concentrations; physical indicators of actual tar and nicotine yields of cigarettes; smoking cessation in adults; evaluation of smoking risk; smoking prevention. 121 p. National Clearinghouse for Drug Abuse Information, Rm 10-A-43, 5600 Fishers Lane, Rockville, MD 20857.

Cannabis: Health Risks — Kalant, Oriana Josseau; Fehr, Kevin O'Brien; Arras, Diana; and Anglin, Lise. Addiction Research Foundation, Toronto, 1983. A comprehensive annotated bibliography (1844-1982); 1,719 annotated references; author and subject indexes. 1,100p. Addiction Research Foundation, Marketing Services, 33 Russell St, Toronto, ON M5S 2S1. $40. ISBN 0-88868-089-3.

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Beyond Health Care: A Working Conference on Healthy Public Policy — Oct 9-12, Toronto, Ontario. Information: Canadian Public Health Association, 1335 Carling Ave, Ste 210, Ottawa, ON K1Z 8N8.

34th Annual Meeting of the Canadian Psychiatric Association — Oct 10-12, Banff, Alberta. Information: Canadian Psychiatric Association, Ste 103, 225 Lisgar, Ottawa, Ontario K2P 0C6.

Workplace 84 "Making the Most of Human Potential." An Employee Assistance Programming Conference — Oct 15-17, Grande Prairie, Alberta. Information: Iyas Abbas, Alberta Alcoholism and Drug Abuse Commission, Provincial Bldg, Rm 2204, 10320 99 St, Grande Prairie, AB T8V 6J4.

5th Annual Meeting of the Canadian Group Psychotherapy Association — Oct 17-20, Ottawa, Ontario. Information: Canadian Group Psychotherapy Association, 30 Bond St, Toronto, ON M5B 1W8.

22nd Annual Scientific and Business Meeting, Ontario Chapter College of Family Physicians — Oct 17-20, Toronto, Ontario. Information: Lyn Robinson, Chairman, 1984 Convention Committee, Ontario Chapter College of Family Physicians of Canada, 4000 Leslie St, Willowdale, ON M2K 2R9.

Addiction Awareness Week — Oct 21-28, Toronto, and other Ontario communities. Information: Joe Taylor, Director of St Vincent de Paul Community Houses, 240 Church St, Toronto, ON M5B 1Z2, or Mary Pakula, Addiction Research Foundation (ARF), 175 College St, Toronto, ON M5T 1P8.

Drug Abuse and Youth, A Public Forum — Oct 22, Toronto, Ontario. Information: Henry Schankula, ARF, 33 Russell St, Toronto, ON M5S 2S1.

Detox Training Programs (Nonmedical) — Oct 22-26, Nov 19-23, Toronto, Ontario. Information: Diane Hobbs, Coordinator of Detox and Rehabilitation Programs, ARF, 33 Russell St, Toronto, ON M5S 2S1.

Gairdner Foundation Lectures (1984) — Oct 25-26, Toronto, Ontario. Information: The Gairdner Foundation, Ste 220, 255 Yorkland Blvd, Willowdale, ON M2J 1S3.

Event 84 Skills Development Training Programs for Employee Assistance Personnel — Oct 28-Nov 1, Oakville, Ontario. Information: James Simon and Jaan Schaer, United Employee Assistance Councils of Ontario, Port Credit Post Office, Box 253, Mississauga, ON L5G 4L8.

Intervention Workshop — Someone I Care About is Abusing Chemicals — Oct 31, Nov 28, Jan 23, Feb 22, Toronto, Ontario. Information: Yvonne Johns, department head, Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Community Development Workshop — Nov 5, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Anxiety Disorders: Theory, Diagnosis and Treatment — Nov 8-9, Toronto, Ontario. Information: Evon Essue, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Drinking and Driving — Together We Can Beat It — Nov 22-23, Winnipeg, Manitoba. Information: Project Prevention, Bldg 3, 2nd fl, 139 Tuxedo Ave, Winnipeg, MB R3N 0H6.

Drinking and Driving: Legal Issue? Social Problem? — Nov 23, Toronto, Ontario. Information: Catherine Blake, coordinator for special events, ARF, 33 Russell Street, Toronto, ON M5S 2S1.

Perspectives on Employee Assistance Programming Course — Nov 26-29, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Chemical Abuse and Your Employee — Nov 28, Jan 23, 1985, Toronto, Ontario. Information: Yvonne Johns, department head, Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Group Therapy Course — Jan 14-18, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Ontario Psychiatric Association Annual Meeting — Jan 24-26, 1985, Toronto, Ontario. Information: Frank E. Cashman, Program Committee Chairman, or Jean Reed, Executive Secretary of the Ontario Psychiatric Association, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Health Promotion Workshop — Feb 13-15, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

The Manager and the Troubled Employee — Feb 20, 1985, Toronto, Ontario. Information: Yvonne Johns, department head, Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

What Every Employer Needs to Know — Feb 20-22, 1985, Toronto, Ontario. Information: Yvonne Johns, department head, Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Behavioral Interventions Course — Mar 27-29, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Parent Resources Institute for Drug Education (PRIDE-Canada Inc) 1st Annual National Conference — May 30-June 1, 1985, Saskatoon, Saskatchewan. Information: Ruth Kell, Convenor, PRIDE-Canada, Ste 111, Thorvaldson Bldg, College of Pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

Summer School for Addiction Studies — July 15-26, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-10, 1985, Calgary, Alberta. Information: Jan Skirrow, Chairman, 34th ICAA Congress, AADAC, 6th fl, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

United States

Introduction to Chemical Dependency and Youth — Oct 3, 10, 17, 24, 31, Livonia, Michigan. Information: Elaine Hughes, Fairlane Health Services Corporation, Ste 1027 Parklane W, Dearborn, MI 48126.

Alcohol and Drug Problems Association (ADPA) Northwestern Regional Conference — Oct 7-9, Seattle, Washington. Information: Eric Scharf, Alcohol and Drug Problems Association, 1101 15th St, NW, #204, Washington, DC 20005.

Smoking Cessation Intervention: How to Help Your Patients Quit — Oct 8, Dallas, Texas. Information: American College of Chest Physicians, 911 Busse Hwy, Parkridge, Illinois 60068.

36th Annual Convention and Scientific Assembly of American Academy of Family Physicians (AAFP) — Oct 9-12, Kansas City, Missouri. Information: The American Academy of Family Physicians, 1740 W 92nd St, Kansas City, MO 64114.

Evaluating Treatment Programs — Oct 10, San Francisco, California. Information: Hazelden Continuing Education, Box 11, Center City, Minnesota 55012.

American Medical Writers Association 44th Annual Conference — Oct 10-13, San Antonio, Texas. Information: American Medical Writers Association, 5272 River Rd, Ste 410, Bethesda MD 20816.

Management Seminar for Alcoholism Professionals — Oct 16-18, Boston, Massachusetts. Information: NAATP, 2082 Michelson Dr, Ste 200, Irvine, California 92715.

American Association for Marriage and Family Therapy 42nd Annual Conference — Oct 18-21, San Francisco, California. Information: AAMFT Conference Committee, 1717 K St, NW, Ste 407, Washington, DC 20006.

1984 Postgraduate Course in Clinical Pharmacology, Drug Development, and Regulation — Oct 22-Oct 26, Rochester, New York. Information: Kristine Niven, Administrator, Center for the Study of Drug Development, The University of Rochester Medical Center, 601 Elmwood Ave, Rochester, NY 14642.

5th Annual Seminar on Alcoholism in the Black Community — Oct 27, Newark, New Jersey. Information: Cody Barrett, c/o RAFT, East Orange General Hospital, 300 Central Ave, East Orange, NJ 07019.

18th Annual Convention of the Association for the Advancement of Behavior Therapy — Nov 1-4, Philadelphia, Pennsylvania. Information: John Martin, Program Chair, AABT, 15 W 36th St, New York, NY 10018.

Current Clinical Psychopharmacology — Nov 2, New Hyde Park, New York. Information: Ann J. Boehme, Continuing Education Coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042.

Alcohol, Drugs, and the Family — Nov 5-9, Minneapolis, Minnesota. Information: Seminar Coordinator, Johnson Institute, 510 1st Ave N, Minneapolis, MN 55403.

4th Annual Fall Conference on Alcoholism — Nov 7-9, Williamsburg, Virginia. Information: Craig Nuckles, director, Riverside Hospital Alcoholism Treatment Program, J. Clyde Morris Blvd, Newport News, VA.

Intervention Skill-Building — Nov 7-9, Houston, Texas. Information: Seminar Coordinator, Johnson Institute, 510 1st Ave N, Minneapolis, MN 55403.

Reality Therapy I — Intensive Week — Nov 7-11, Milwaukee, Wisconsin. Information: Patricia Faubert, Training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

Reality Therapy II — Intensive Week — Nov 7-11, Milwaukee, Wisconsin. Information: Patricia Faubert, Training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

AMERSA (Association for Medical Education and Research in Substance Abuse) 8th Annual Conference — Nov 8-9, Washington, DC. Information: Conference coordinator, c/o David Lewis, Brown University, Program in Medicine, Box G, Providence, Rhode Island 02912.

Intimacy, Shame and Alcoholic Family Recovery — Nov 9-10, Farmington Hills, Michigan. Information: Elaine Hughes, Fairlane Health Services Corporation, Ste 1027 Parklane W, Dearborn, MI 48126.

2nd National Conference on Alcohol and Drug Abuse Programming for Colleges and Universities — Nov 11-14, Boston, Massachusetts. Information: Eric Scharf, Alcohol and Drug Problems Association, 1101 15th St, NW, #204, Washington, DC 20005.

Alcoholism, Drug Dependence, and Family Recovery — Nov 12-16, Minneapolis, Minnesota. Information: Seminar Coordinator, Johnson Institute, 510 1st Ave N, Minneapolis, MN 55403.

Hope for the Children — Nov 14-15, Santa Barbara, California. Information: National Council on Alcoholism, 133 E Haley St, Santa Barbara, CA 93101.

Kid's Stuff III: A Conference on the Prevention of Alcohol/Chemical Abuse Among Youth — Nov 14-16, Austin, Texas. Information: Peggy Frias-Lynch, Texas Commission on Alcoholism, 1705 Guadalupe St, Austin, TX 78701.

Assessing and Treating Adolescents for Alcohol and Drug Abuse — Nov 15-17, Dallas, Texas. Information: Seminar Coordinator, Johnson Institute, 510 1st Ave N, Minneapolis, MN 55403.

Children of Alcoholics: Break the Silence — Nov 16, White Plains, New York. Information: NCA-/Westchester, Inc, 10 Longview Ave, White Plains, NY 10601.

Healing Adult Children of Alcoholics, "Laughter, Creativity and Play" — Nov 17-18, Santa Barbara, California. Information: National Council on Alcoholism, 133 Haley St, Santa Barbara, CA 93101.

Assessing Community Needs for Alcoholism, Drug Abuse, and Mental Health Services — Nov 27-29, Tucson, Arizona. Information: Tom Donovan, ADAAPT, 4500 E Speedway, Ste 21, Tucson, AZ 85712.

The 9th Southeastern Conference on Alcohol and Drug Abuse (SECAD 9) — Nov 28-Dec 2, Atlanta, Georgia. Information: Charter Medical Corporation, Addictive Disease Division, 5780 Peachtree Dunwoody Rd, Ste 170, Atlanta, GA 30342.

Cultural Aspects of Alcoholism — Dec 6-8, Beaumont, Texas. Information: Bill Rosemon, Texas Black Alcoholism Council, PO Box 8066, Houston, TX 77288.

Family Recovery from Alcoholism and Drug Dependence — Dec 10-14, Minneapolis, Minnesota. Information: Seminar Coordinator, Johnson Institute, 510 1st Ave N, Minneapolis, MN 55403.

Adult Children of Alcoholics Round-Up — Feb 22-24, 1985, Orlando, Florida. Information: The US Journal, 2119-A Hollywood Blvd, Hollywood, FL 33020.

1st Annual Convention on Children of Alcoholics — Feb 24-28, 1985, Orlando, Florida. Information: Conference Coordinator/Disney, The US Journal, 2119-A Hollywood Blvd, Hollywood, FL 33020.

NECAD Northeastern Conference on Alcoholism and Drug Dependence — Mar 24-27, 1985, Newport, Rhode Island. Information: Edgehill Newport Foundation, Beacon Hill Road, Ste 106, Newport, RI 02840.

Abroad

International Workshop on Punishment and/or Treatment for Driving under the Influence of Alcohol and other Drugs. Current Concepts and Prospectives. Pros and Cons. — Oct 19-20, Stockholm, Sweden. Information: ICADTS, Box 5815, S-102 48 Stockholm, Sweden.

"Addiction: A Hundred Years On" Centennial Symposium — Oct 25-26, London, England. Information: The Royal Society, 6 Carlton House Terrace, London SWI, England.

2nd Inter-American Symposium on Health Education — Nov 4-9, 1984, Acapulco, Mexico. Information: Symposium Steering Committee, c/o NARO, PO Box 2305, Station "D," Ottawa, Ontario, K1P 5K0.

Prophylactics of Drug Abuse — Dec 10-12, Warsaw, Poland. Information: Secretariat of the Symposium, Society for Prevention of Drug Abuse, Aleje Ujazdowskie 22, 00-478 Warsaw, Poland.

International Youth Forum on Alcohol and Drugs — July 9-12, 1985, Cardiff, United Kingdom. Information: Dr Myrddin Evans, Addiction Unit, South Glamorgan Health Authority, Whitchurch Hospital, Whitchurch, Cardiff, CE4 7XB, United Kingdom.

4th European Acupuncture and Alternative Medicine Symposium and World Symposium on Moratherapy and Lasertherapy — Aug 30-Sept 1, 1985, Copenhagen, Denmark. Information: Secretary General, Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

2nd National Drug Institute — Social Change and Drug Use Patterns — Aug 14-16, 1985, Darwin, Northern Territory, Australia. Information: NDI Planning Committee, NT Drug and Alcohol Bureau, department of Health, GPO Box 1701, Darwin, NT 5794, Australia.

12th International Conference on Health Education — Sept 1-6, 1985, Dublin, Ireland. Information: Dr H. D. Crawley, Director, Health Education Bureau, 34 Upper Mount St, Dublin, Ireland.

High youth unemployment a key factor

Heroin: social anesthetic for young Britons

By Alan Massam

LONDON — *The 1984 spectre of hopeless housing estates with mum on Valium, dad on the booze, and the kids on smack, is already with us.*

So wrote British-based drugs researcher, Tim Malyon, 12 months ago as the year of George Orwell's nightmare vision of the future approached. As 1984 began, British Prime Minister Margaret Thatcher (fearful, perhaps, of being described as Big Sister) challenged the spate of interest in the Orwell satire, insisting that the author had been wrong. 1984 was a hopeful and promising time for Britons, she said.

But the year has not been politically comfortable for the Iron Lady of British politics. The promised economic recovery has, to say the least, faltered. And her policy of high unemployment is producing increasing signs of dangerous social consequences.

I refer to the heroin epidemic.

The latest official pronouncement on this subject came on August 16 from The Home Office, which is the government department responsible for stemming drug abuse through law enforcement. It announced that the number of drug users addicted to heroin increased by 42% in 1983, with many of the new addicts less than 20 years of age. During the same period, the number of heroin seizures by police and customs doubled to 1,900 — six times the annual average for the 1970s.

Statistics in a government document usually fail to arouse a great deal of public interest — particularly when the country is locked in a crippling dispute between the same government and the nation's coalminers.

Figures spell trouble

But David Mellor, government minister responsible for Home Office policy on drug abuse, seemed conscious that the 1983 figures spelled trouble.

He announced that "a major campaign against the drug pushers and other criminal elements" was already under way. And he added: "This evil trade in misery is an abhorrence in our society and can ruin and destroy its victims. Let no one doubt the strength of our will to stop it."

The voice of doubt came quickly afterwards, however. David Alton, a Liberal Member of Parliament (MP) who has actively campaigned against the wave of drug addiction, pointed out that recent government policies were exacerbating the situation.

He said security at England's ports must be improved, which meant increasing the number of customs officers instead of reducing them as the government had recently done.

"Secondly, the government must give our young people policies which strengthen their self-esteem and self-respect, enhance their future prospects, and end the feelings of despair which drive them to drug abuse," Mr Alton added.

Unemployment key

A close look at Britain's current heroin problem reveals characteristics which clearly suggest high youth unemployment as a key factor. Heroin abuse is no longer a phenomenon affecting only the rootless drop-outs who were the addict stereotypes of the 1960s and 1970s.

Tim Malyon wrote: "The size of this stereotype addict population has indeed increased, but taking heroin is no longer a fringe activity. It has penetrated well-established, hitherto stable sections of British society. Many working-class (housing) estates . . . are experiencing a huge rise in addiction among teenage children still living at home."

London's Oxford Street

Golobitsh

'Every kid on every block is getting into some kind of drugs . . . to escape the boredom and frustration. They've got no work; nothing to do. They are just looking for a way to kill time.'

In case Mr Mellor needed any evidence, a recent television documentary (TV Eye — Heroin, The Local Connection) investigated the availability of the drug on an inner-city housing estate chosen at random.

The program went to the northern town of Rochdale, where unemployment is running at 16%.

Local magistrate Barry Dean said: "The drug problem in Rochdale has grown tremendously over the last couple of years, and it seems now to be drawing in a lot more younger people. It is difficult to be precise, obviously, because we don't know the extent of the problem. But I am convinced now that the problem has grown to frightening proportions."

Shattering effect

Local MP Cyril Smith said: "I've had parents telling me that their children have robbed the home, sold things, pinched from purses, in order to get money to buy a 'fix.' There is no doubt at all that heroin addiction has a shattering effect on family life and is having a shattering effect on certain families in Rochdale at the present time."

The program's researcher, Peter Gill, sent an undercover reporter to a typical Rochdale housing area, the Ashfield Valley Estate, where he found heroin abuse was "widespread." But the main reason for this "sheer scale of abuse" was the fact that the heroin was being smoked and not injected.

Regional specialist in drug dependency, John Strang, told the program: "Of course it is not a new phenomenon. Heroin and other opiates have been smoked for centuries. But a decade ago one was looking at a drug which was almost always being injected and was, therefore, something which the ordinary person in the street would in no way consider trying.

"But now, by virtue of the fact that it is being marketed as a drug which can be smoked, many more people seem to be willing to try it. I think one can see it as a masterpiece of marketing enterprise."

Later Dr Strang confirmed, however, that smoking instead of injecting heroin did not necessarily reduce its potential for addiction.

And the freelance reporter, Richard Beerman, summed up the program: "I think you would find that every kid on every block is getting into some kind of drugs — largely heroin because it is very popular and very easily available. There is also acid (LSD), speed (methamphetamine), or whatever they can lay their hands on. Anything to escape the boredom and frustration. They've got no work, nothing to do. They are just looking for a way to kill time."

No-hope generation

Trevor Jones, a sociologist who did a three-month survey of heroin abuse in the London borough of Islington, found children in their early teens "chasing the dragon" (smoking heroin) on some housing estates. He said: "Many unemployed working-class youths view themselves as a no-hope, no-future generation. The attraction of a social anesthetic like heroin is obvious."

At a practical level, he gave a drop in street price and wide availability of the drug in pubs and on housing estates as the main reason for the growth in heroin abuse. Some addicts had been found to have started experimenting at age 13.

Mr Malyon believes the heroin black market is so profitable that throughout history it has survived by "becoming embedded through corruption in the political and law enforcement systems that supposedly exist to suppress it."

He says he knows of no example of heroin abuse being brought under control by law enforcement methods. Customs seizures may reduce the flow of the drug entering a country, but to look to them for any kind of solution to the problem is "totally impractical."

"It is within the community, therefore, that action to stop dealers and provide primary treatment and rehabilitation must be focused," he says. "Given the present lack of community facilities, hopeless employment prospects, and terrible housing conditions, the task seems insurmountable."

At press time neither the Health Education Council nor the Department of Health and Social Security could report any new initiatives by the government since the announcement of the latest Home Office figures on drug abuse.

Mellor: evil trade in misery

Thatcher: Orwell was wrong

THE BACK PAGE

Beverage industry answers its critics

p7

A week in the life of

THE NOVA SCOTIA COMMISSION ON DRUG DEPENDENCY

Centre Section

Pain management:

Excerpts from an expert committee report to the Canadian government

The Back Page

Vol. 13 No. 11 2nd Class Mail Reg No 2776 TORONTO November 1, 1984

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

East/West alcoholism comparable

By Michael Kesse

JERUSALEM — East does meet West in the alcoholism field.

"People are the same everywhere," Professor Vladimir Hudolin, director of the department for neurology, psychiatry, alcoholism, and other dependencies, Zagreb University, Yugoslavia, argued here at the International Congress on Alcohol Dependence, the Family, and the Community.

He was responding to a suggestion that there was a much

Hudolin: worldwide problem

greater alcoholism problem in the Eastern bloc. "I've travelled extensively in both the Eastern bloc and in the West (Western Europe, the United States, etc), and the main differences I've seen are the methods of classification in different countries," he said. "In a few months I'm scheduled to be in Moscow, and I'm quite sure that there I'll be asked: Isn't the problem much worse in the West?"

Prof Hudolin said: "The most appalling cases of alcoholism I've seen were in the US among the Navajo Indians. And, at the time, I said: 'If I didn't know you were an American Indian, I'd think you were a peasant woman in Yugoslavia.'

"Bulgaria said it had no alcoholism, but now that country is developing programs for alcoholism. Rumania still claims it has no problem of alcoholism. I heard the same thing about Israel before I arrived, but now that I'm here I see that Israel has a well-developed problem."

Alcoholism is world wide, he said.

Prof Hudolin said, on the ba-

(See — Most — page 2)

Cocaine is as destructive as heroin says US report on drug strategy

By Harvey McConnell

WASHINGTON — Cooperative efforts by federal, state, and local government, and close involvement of the private sector remain at the heart of the United States strategy for prevention of drug abuse and drug trafficking.

US President Ronald Reagan, in a preface to the biennial report, said that in the last three years "permissive attitudes have given away to a sense of responsibility to ourselves, to our families, and to our country. Hopelessness and helplessness have been replaced with optimism and a willingness to work toward a better future."

While the 1970s growth of drug abuse may have been halted, millions of US residents are still affected by alcohol and other drug problems, the President added. "Our goal is clear. We intend to conquer drug abuse and ensure a safe and productive future for our children and our nation."

The 1984 strategy points out that in the 1970s the highest priority was given to heroin. Today, while opiate abuse continues to cause serious problems, "intensified use patterns and recent research leave little doubt that cocaine is potentially as destructive to health as heroin."

Responses must be made to those involved in other drugs of abuse, including alcohol and marijuana.

The strategy declares that there is no attempt to dictate from a national level the relative priorities for local response to drug problems. "While drug abuse is a menace to our entire society, the drug problems of a large city may be quite different from those of a small town. Each locality must determine its own priorities and must have the flexibility to fashion appropriate responses."

Optimum effort is being sought from the network of federal, state, and local governments as well as the expanding private sector — business and volunteer — to reduce drug abuse.

"Described simply, real success is achieved when those people most affected by drug and alcohol abuse are directly involved in solving their own problems," the strategy report says.

Awareness and education are keys to long-term success in stopping drug abuse and drug-related crime in society, the strategy says. Special emphasis has been placed by the Reagan administration, working closely with the private sector, to discourage alcohol and other drug use among school children.

On the law enforcement side of the equation, the strategy notes 14 federal agencies are currently involved in the drug law enforcement effort. The federal budget for drug law enforcement will exceed $1.2 billion in fiscal 1985, a 75% increase since 1981.

Reagan: goal is clear

On the international scene, the strategy says major law enforcement and eradication efforts have begun in Colombia; Pakistan has taken steps to try to regain control of outlying opium producing areas; and military forces in Thailand are attacking opium traffickers in the border areas.

At the same time, the strategy admits "achieving control of illicit production is a formidable challenge because the worldwide supply of marijuana, cocaine, heroin, and other drugs is large and complex. Production is widely distributed and often concentrated in areas which are not policed or controlled by the recognized government."

The strategy recognizes that detoxification and treatment of the individual drug abuser is an essential element in the comprehensive strategy to reduce the effects of alcohol and other drug abuse in the US.

The strategy says meeting acute medical needs associated with drug emergencies, providing treatment for chronic drug abusers, and efforts toward prevention and early, non-medical intervention are often viewed as competitors for scarce resources. All are necessary, however, if a community is to engage in anything more than a holding action.

Support is given by the strategy to expansion of research aimed at understanding the causes and consequences of drug abuse and the application of that knowledge to alcohol and other drug abuse prevention, treatment, and rehabilitation.

Encouragement is being given to the pharmaceutical industry, colleges, universities, and professional health care organizations to undertake more extensive drug abuse research.

Advice fosters guilt, anxiety

MDs pick on pregnant smokers

By Betty Lou Lee

HAMILTON — Go easy on pregnant women who smoke. They've got enough problems.

That's the advice Murray Enkin, MD, professor of obstetrics and gynecology at McMaster University here, is giving colleagues.

"By dumping on pregnant women, we're taking the heat off the problem and probably doing a lot of harm, principally because of guilt and raised anxiety," he told **The Journal**. "They have bad effects on the pregnant woman and the baby as well.

"And if anything goes wrong, as can happen to any baby, the mother will never forgive herself.

"I used to be absolutely cruel to pregnant women, and I don't think I was any worse than any other doctor."

But, after an extensive review of the literature on smoking and pregnancy, he has changed his attitude.

In a recent article in the periodical, *BIRTH*, he writes: "Smoking during pregnancy is not good for either mother or baby, but neither is smoking at any time.

"Smoking mothers are neither ignorant of the supposed consequences of their actions, nor selfish and irresponsible. Their failure to comply with our well-meant advice may derive from a different assessment of the evidence, with reliance on personal experience rather than the wisdom of the so-called experts. ('My cousin smoked all her pregnancy and had a nine-pound healthy baby.')

"Sometimes the smoking may be important to a woman's ability to cope with the stress of pregnancy. While it may (or may not) be true that the pregnant woman, concerned for the well-being of her child, may be more compliant with anti-smoking advice, for us to seize on the vulnerable time of pregnancy to attempt to induce lifetime changes at the expense of possible lifetime guilt seems cruel indeed.

"A woman deserves to be informed, not only about what is known of the adverse effects of smoking during pregnancy, but also that these effects are only one small part of a much larger picture. A non-judgemental, informative discussion will serve her far better than the vehement exhortation so commonly seen and heard."

In his discussion of the scientific literature, Dr Enkin notes that

(See — Smoking — page 2)

INSIDE

NEWS

Briefly...

Alcohol deaths down

WASHINGTON — Deaths from alcohol abuse are on the decline in the United States. Quoting from a study by The Metropolitan Life Insurance Company, *Medical News* reports that approximately 28,000 people died of alcohol abuse in 1983 compared with 33,350 in 1973. The report indicates that the US midwest is leading the way in reduced deaths.

Drug seizures

LONDON — Seizures of illegal drugs here increased by more than one-fifth in 1983 over the previous year, and the number of offences involving class A "hard drugs" rose more than 40%, says a report in *Doctor*. Seizures of heroin doubled, with LSD seizures up 10%, cocaine up 57%, and amphetamine, dexamphetamine, and levamphetamine up about 42%. The report from the Home Office indicates the majority of illegal drugs seized in 1983 were cannabis derivatives, mainly cannabis resin.

Low tar helps

BELFAST — Researchers here report that switching from medium- to low-tar cigarettes can help, despite the fact most smokers compensate for lower tar levels by increasing smoking intensity. *Medical News* reports that in a recent study by Dr Roger Rawbone, middle-tar smokers smoking low-tar cigarettes did vary their smoking pattern to increase their intake of nicotine and tar. But, this was more than compensated for by the lower tar delivery of the milder cigarettes, resulting in a 24% lower intake overall.

Maori dilemma

AUCKLAND — Alcohol is the major cause of problems among their people, say a group of young, urban Maoris in a recent study here. Some, interviewed by Auckland University's Alcohol Research Unit, had decided to cut down on their drinking or give up completely because they see alcohol as a "reason for the poor, depressed conditions of many Maori people." John Robertson, chairman of the New Zealand Alcoholic Liquor Advisory Commission (ALAC), said in the ALAC newsletter the study reinforces the need for special planning to deal with the problems.

Action on Health

TORONTO — A new Ontario committee, headed by former World Cup ski champion Steve Podborski, will aim at coordinating public and private sector health promotion activities. Health Minister Keith Norton said the Action Group on Health Promotion will deal in five key areas: improved physical fitness, cessation of smoking, moderation in the use of alcohol, good nutrition, and increased awareness of personal responsibility for health. The group will be responsible for recommending specific promotion and prevention activities, including programs on preventive treatment and rehabilitation.

US says no to medical use of heroin

By Harvey McConnell

WASHINGTON — Political fear and opposition by the medical establishment combined to quash efforts in the United States Congress to allow heroin to be used for pain relief in terminal cancer patients.

By a vote of 355 to 55, the House of Representatives rejected proposed legislation which would have allowed doctors to prescribe heroin. Heroin was outlawed in the US in 1924.

Massive opposition was mounted by the American Medical Association (AMA) and officials of the Reagan administration to the idea of a four-year experiment (**The Journal**, May). Opponents claimed it would open the way to further legalization of heroin and give the "wrong signal" about drugs.

Representative Henry Waxman, a sponsor of the bill, said: "People were afraid to vote in any way, shape, or form for anything that sounded like the legalization of heroin. They were afraid they would be campaigned against on the issue."

The director of a national organization in the substance abuse field, who wished to remain anonymous, told **The Journal**: "The truth, which the politicians, the AMA, and others will never say in public is that, given the drug scene and medical system here in the US, if heroin is legalized — even for limited use — there will be a huge increase in physicians and nurses using heroin, and massive diversion from the hospitals to the streets."

Coming up in The Journal:

Would lifting the ban on heroin pose a threat to the medical profession?

Access to heroin could tempt doctors

By Betty Lou Lee

MONTREAL — If heroin is reintroduced for medical use in Canada, it may result in physicians becoming addicted to it, a Calgary psychiatrist suggests.

Julio Arboleda-Florez, chief of forensic services at Calgary General Hospital, and professor of psychiatry at the University of Calgary, says there aren't statistics on heroin addiction among doctors before importation of the drug was banned by the federal government in 1954.

"But it would not be farfetched to conclude that if it becomes available again, as proposed by the Canadian Medical Association (The Journal, Oct), emotionally impaired physicians who tend to abuse drugs would move away from tranquillizers and other analgesics and onto heroin," he told the annual meeting here of the Royal College of Physicians and Surgeons of Canada.

"Perhaps, after all, the banning of heroin was not a bad idea from the point of view of the potentially impaired physician, and it is sad that the (Canadian Medical Association) apparently did not give any consideration to this disturbing possibility when it passed its resolution (calling for reinstatement of the drug)."

See — Pain management —The Back Page

'No problem of drug addiction in socialist countries'

Soviet prof chastizes West's drug policies

MOSCOW — Attempts by some Western countries to weaken control of drugs like marijuana is a dangerous trend, medical scientist Eduard Babayan warned in a recent *TASS* interview.

Professor Babayan, who is chief of the USSR delegation to the United Nations Commission on Narcotic Drugs, said proposals were being put forward in the United States, the Netherlands, and other countries, "to legalize the use of a number of narcotics."

He told the Soviet news agency that official statistics, submitted to the UN commission, reveal that 45 million US residents use marijuana and 11 million suffer from its effects, while the use of cocaine is also on the increase, and the US has a "vast number" of heroin addicts.

Prof Babayan, also a director of the International Council on Alcohol and Addictions, expressed "tremendous astonishment" that the mayor of Amsterdam advocates the legalization of heroin. Less than a year ago, he said, a report revealed that Amsterdam had become one of the biggest centres of heroin addiction.

All kinds of tricks are tried to get around existing laws, Prof Babayan said.

In the US, hundreds of thousands suffer from cocaine addiction, but the book, *Federal Strategy for Combatting the Use and Trafficking of Narcotics*, lists cocaine as a non-narcotic drug, he added.

"An accidental error, or tactics?" asked Prof Babayan, adding: "I believe the latter is true."

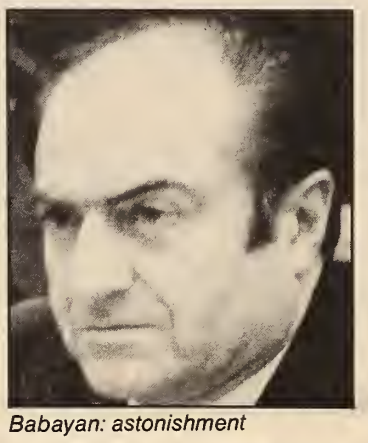
He spoke of attempts to claim that the socialist countries have something to do with the supply of narcotics to the capitalist world.

"There is actually no problem of drug addiction in the socialist countries.

"Only 2,500 to 3,500 such cases of the dangerous disease are registered in the USSR in the course of a year, and these are chiefly disabled persons — chronic patients using narcotics as a medicine.

"For a decade now, the sowing of the opium poppy has been prohibited in Soviet territory, and the needs of the health protection system are met through opium imports from India. Cocaine for eye disease therapy is also purchased abroad.

"Soviet medicine has sharply reduced the use of the preparations of the group of morphia and codeine by using, in particular, methods of electroanalgesia," Prof Babayan said.



Babayan: astonishment

"The USSR is a party to all the main international conventions on control over narcotic drugs and took part in drawing up these treaties. It permanently advocates strict control measures."

Paradoxically, Prof Babayan told *TASS*, the socialist countries, which have no drug addiction problem, favor control, whereas the West, where the situation is grim, is pursuing a policy of legalizing and free trafficking in narcotic drugs.

He urged all governments to pool their efforts to get rid of this threat to health.

Most alcoholics socially stable

(from page 1)

sis of his extensive experience in Croatia, one of the constituent republics of Yugoslavia, that "excellent success" had been obtained in treating those who developed alcoholism late in life, in their 50s or 60s. Treatment generally consisted of restructuring the family and eliminating family problems. It was also important to make these "late-comers" to alcoholism dependent on a group, "for they begin to give love to this group, and they receive love back."

Prof Hudolin, who has worked with alcoholics for the past 30 years, said the "stereotype alcoholic," the skid-row type, represents a small group.

"Most alcoholics today are people in jobs, people with important social and economic positions, and the mothers and housewives of families of good standing. More than 50% of all those who came for hospital treatment in Croatia from 1965 to 1981 were in regular employment."

On the basis of his work in Croatia, and his visits and studies of the situation in other countries, he concluded that not even the richest countries with the largest number of trained personnel will be able in the future to provide hospital treatment for alcoholics. Thus, the treatment of alcoholics must be shifted to those within the community, or place of employment, and to those concerned with primary health care, such as the general practitioner, the social worker, the district nurse, paraprofessionals, and volunteers.

"Individual treatment is, in any practical sense, not possible.

"We believe that alcoholism cannot be cured except by total abstinence. We demand abstinence also from family members living in intimate interaction with the alcoholic. Lasting abstinence with improved work, social, and family relationships has been achieved in 60% of the cases, with the follow-up survey being taken one year after initial success was achieved."

Smoking only an indicator

(from page 1)

maternal smoking has been associated with low birth-weight babies, infertility, spontaneous abortion, sudden infant death syndrome, later respiratory symptoms in the child, and developmental delays in the child.

There is biological evidence to support a causal relationship between smoking and these effects, since toxic substances in smoke cross the placenta, and nicotine can constrict blood vessels and thus reduce nutrient and oxygen supplies to the baby.

But he questions whether the smoking is the cause of all these adverse effects, "or is it merely a marker for a woman who was predisposed to a particular type of reproductive outcome — an indicator perhaps of some other combination of factors which may cause both the smoking and the adverse consequences?"

A 1971 study, for example, showed that women who did not start smoking until after their baby was born still had a higher incidence of low birth-weight babies.

He noted that smoking women are more likely to be from a lower socio-economic class, to live in a city, to have less medical care during and after pregnancy, and to be working outside the home.

They are more likely to drink coffee, beer, and whisky, "and to indulge in these to excess." They have less schooling and are more likely to be unmarried.

Enkin

Dr Enkin says that studies which control for these variables show a markedly lessened effect for smoking *per se*.

NEWS

Parents' anti-drug crusades praised by ADAMHA chief

By Harvey McConnell

WASHINGTON — Parent anti-drug groups should shift the emphasis from marijuana to other drugs, especially cocaine and alcohol, believes Ian Macdonald, MD, administrator of the United States Alcohol, Drug Abuse, and Mental Health Administration.

Dr Macdonald told the annual conference here of the National Federation of Parents for Drug-Free Youth that while it has done marvelous work on the dangers of marijuana, "we do need to learn about cocaine, and we do need to pay attention to alcohol."

He noted that young people of the 1960s and 1970s who became heavily involved with alcohol and other drugs "are now the parents of kids coming up in the 1980s and 1990s." There is a need to know how the children will be affected by their parents' alcohol and other drug use.

Dr Macdonald said while prevention has been stressed, there has not been enough emphasis on the fact that treatment can work. "There are lots of doctors who don't know you can free a kid who has got a marijuana problem or that you can free an adult with an alcohol problem." A wide range of people need to be better informed: from the media to teachers to doctors, he said.

Macdonald: emphasis shifts

Dr Macdonald said the drug use and abuse problem is unusual in that it took the dedicated work of amateurs, especially parents, to show the professionals they were wrong.

In the 1960s and the 1970s, many federal publications, and such organizations as the American Academy of Pediatrics and the American Psychological Association, "were all telling us what we were seeing wasn't happening — that this was a stage the kids were going through and that we needed to teach them moderation and responsible use. But we were smart enough not to believe that."

And if professionals were approached by worried parents "we (parents) were told you don't know what you are doing, you are being over-protective, and you don't understand kids and what goes on."

Dr Macdonald said the situation for illicit drugs was the opposite for licit ones. The US Food and Drug Administration has to approve all new drugs, "but, in this situation we, the amateurs, had to prove that a drug was not okay to the professionals."

Now the parents' movement is nationwide and has thousands of chapters and members. And, Dr Macdonald noted, "we have different kinds of kids.

"We had 18 straight years of declining SAT (student aptitude test) scores and right along with it rising marijuana use. Now, as marijuana rates appear to have turned down, the SAT scores have turned up."

'Moralistic policies' limit hepatitis program

Vaccine misses high-risk groups

By Betty Lou Lee

MONTREAL — Moralistic government policies against some groups at high risk for hepatitis B, such as intravenous drug users and homosexual men, are one reason relatively few Canadians have been vaccinated against the disease, says a liver specialist.

The vaccine's $125 cost is another major factor.

James G. Rankin, MD, director of the Canadian Liver Foundation Epidemiology Unit, University of Toronto, estimates that only 5% of perhaps one million Canadians in high-risk groups have received the vaccine, which has been available for two years.

Alberta has the most comprehensive free vaccine program, but it excludes drug abusers and homosexuals from the at-risk groups who qualify.

"I think it comes down to moralistic terms," Dr Rankin told the annual meeting here of the Royal College of Physicians and Surgeons of Canada.

No province provides the vaccine free to all the groups at risk, which include health professionals in contact with blood or blood products; the mentally retarded in institutions; ethnic groups from South-East Asia, the Pacific Islands, and parts of Africa; those who use blood products, like hemophiliacs; and those on chronic renal dialysis.

The Ontario government bought 10,000 doses in 1982 and still has most of it in storage, Dr Rankin said. The Ontario ministry of community and social services offered it free to residents and care-givers in institutions for the mentally retarded, but the ministry of health has expected hospitals to pay for it out of their global budgets, at half price, if they want to vaccinate staff members.

Dr Rankin said more money is being spent on diagnostic tests for hepatitis B, than for vaccinating against it.

The incidence of reported cases has risen to 12.4 per 100,000 in 1983, from 0.5 per 100,000 in 1971. In 1978, it is estimated the disease caused 14 deaths from fulminant hepatitis, 424 deaths from cirrhosis, and 97 deaths from hepatocellular cancer.

By August 1984, only 39 of 183 Canadian general hospitals surveyed had vaccination programs for their staff.

Harsh words on US cigs warn public of hazards

WASHINGTON — New cigarette warning labels have been approved by the United States Congress — and the tobacco industry.

The warnings are contained in bills passed by voice votes in both houses of Congress. Before final approval, there were compromises between the industry and health groups pushing for label changes.

There are four warnings, which will change every three months. Each label, which will be 50% larger than the current warning, will be preceded by the statement "Surgeon General's Warning."

New warnings are:

- **"Smoking causes lung cancer, heart disease, emphysema and may complicate pregnancy."**
- **"Quitting smoking now greatly reduces serious risks to your health."**
- **"Smoking by pregnant women may result in fetal injury, premature birth and low birthweight."**
- **"Cigarette smoke contains carbon monoxide."**

Under the compromise with industry, a statement was deleted which said that cigarette smoking has been found to cause at least 300,000 deaths in the US each year, and that it is a major cause of cancer and other diseases.

Cheap sherry and the great floor price fiasco

By Wayne Howell

The time: circa 1995. The place: outside a local corner store in Toronto.

Three teenagers are drinking Canadian sherry out of brown paper bags and arguing about whether they should pop into the store for another go at the video games, or pool their quarters and buy another bottle of sherry. They are approached by an old-timer mooching spare change for the proverbial "cup of coffee."

"Get lost pops," says the first teenager.

The second holds up a quarter and demands that the old man dance for it.

"No, no," smirks the third, "we want a song and a dance."

The old-timer sighs:

"I can't sing and I can't dance — but I can tell you a story that might amuse you. It has to do with what you've got concealed in that bag."

"Lay it on us, old man," says the first teenager, "and if it holds our interest as much as a game of Pac-Man, you got yourself a quarter."

"There was a time, a long time ago," begins the old man, "when you couldn't buy cheap sherry at corner stores."

"Don't pull our legs, pop; they don't call these convenience stores for nothin'."

"It's true, I swear it. Why there was even a time in Ontario when you couldn't buy booze without a licence."

This is too much. The teenagers whoop and laugh and roll their eyes. They've got a live one here — crazier than all hell, of course, but who knows, that might make for a better tale.

"Let me start at the beginning. The Ontario wine industry got going in the years prior to what we called 'the great war'. . . ."

"What great war?"

"Forget that. I'll try to use year-dates from now on. In the beginning, and right up until the 1950s, they made wine out of the native grapes, but the wine was so awful they had to run it through the chemistry lab, tart it up with alcohol, and sell it as 'sherry' or 'port.' Now in the 1960s . . . ."

"Hey, I heard of the 60s. People went to Woodstruck and took off their clothes and things like that."

"Anyway, in the 1960s, Ontarians developed a taste for European-style wines and wouldn't drink the Ontario product anymore, so the Ontario government gave the grape farmers a lot of interest-free loans so they could convert their vineyards from the crummy native grapes to European varieties.

"Pretty soon the Ontario winemakers started to make European-style table wines, but they were neither good enough nor cheap enough to really capture the market. So, during the 1970s, the Ontario government came up with clever little taxing schemes to keep Ontario wines cheaper than imported wines. However, the Europeans shot every one of these little schemes down with their GATTling gun. In other words, they used GATT (General Agreement on Trade and Tariffs) to pressure the Canadian federal government to nix the Ontario schemes because they were contrary to international agreements Canada had signed.

"Despite this, however, the Ontario schemes were usually in place long enough to give the domestic industry a boost, to the point that, in 1982, Ontario wines had captured 52% of the table wine market, and the old bread-and-butter trade of Ontario wineries (sherry for winos) was rapidly becoming a thing of the past. Indeed, by 1982, several 'boutique' wineries were producing European-style table wines of exceptional quality.

"Everything was coming up roses in 1982. Canadian table wines were doing as well as could be expected in a tough market; boutique wineries were springing up all over the place; and the Ontario government was putting the finishing touches on its latest and greatest tax-protection scheme: the 'base reference price.' This scheme, which was introduced in 1983, was a wonder; it effectively kept Canadian wines cheaper than even the cheapest of imports, but it did it in such a way that it didn't violate the GATT agreement. Anyway, the Europeans weren't complaining too much because, under this scheme, they got paid exorbitant prices for their poorest wine.

"For instance, an Italian exporter of red wine that even the Italians wouldn't drink would go to the Ontario Liquor Board and say, 'I'll give you a deal — $10 a case.' And the Liquor Board man would say, 'I regret to inform you that our floor price system does not allow us to pay $10 a case for cheap Italian red wine. The best we can do is offer you twice that — $20 dollars a case, take it or leave it."

"You're putting us on again, pops."

"It's true, I swear it. But this wasn't the fatal flaw in the floor price system. The fatal flaw was that, even with the floor price, a litre of Canadian wine was only 65 cents cheaper than a litre of Italian and, because of a weak Franc, a litre of French wine came in at the same price as the Italian. The upshot of this was that Ontarians said: 'Why not go for the French stuff.' And they did. By late 1984, the Italian imports had dropped by 50%, French imports had increased by 70%, and the Ontario wineries were on the ropes. Just when they had hoped to recover some of the money invested in the European grape plantings, their market share plummeted.

"The grand scheme to boost the Ontario wine industry was a complete and total disaster. To the point that the wineries, some of which were threatened with bankruptcy, took up the old refrain: put us in the corner stores or our industry will surely die.

"Now, my memory gets a little hazy from this point on — at my age, the long-term memory is better than the short term — but I seem to recall that 1985 was an election year in Ontario. And the political heat generated by the great 'floor price fiasco' resulted in the new government setting up a commission to look into the possibilities of 'local wines at local stores,' which was the slogan adopted in 1986 by the Ontario Wine Institute. And I think it was in 1987 or 1988 that local wines did come to local stores, despite the fact that the commission was against it, because the wine industry was still sickly and the government felt guilty about having caused the whole mess in the first place.

"As I recall, the wineries did try to sell table wines made from the grapes planted in the 60s and 70s for a time, but nobody believed a wine you could buy at a corner store was any good, and eventually the wineries gave up and went back to their pre-war roots — back to native grapes, the chemistry lab, and fortification with brandy or raw alcohol. That's what the corner-store consumers seemed to want anyway, so why fight it.

"And that, my young friends, explains why you are able to sip domestic sherry out of a paper bag in front of a corner store in 1995. A curious tale, is it not?"

"I don't believe a word of it, pops," says the first teenager. But he gives the old man a quarter anyway.

NEWS

RESEARCH UPDATE

Drugs may reduce cocaine side-effects

The anti-depressant drug trazodone (Desyrel) has been found to reduce feelings of tension and shakiness following cocaine ingestion. Interaction of trazodone hydrochloride (a non-tricyclic triazolopyridine derivative) and cocaine hydrochloride was tested with eight healthy men who had all sniffed cocaine infrequently. Following the ingestion of 100 milligrams of trazodone or placebo, subjects swallowed 2 mg per kilogram of cocaine hydrochloride and were monitored for six hours for both physiologic and subjective changes. The researchers at the Drug Dependence Research Center, Langley Porter Psychiatric Institute, University of California, San Francisco, found that while ingestion of trazodone produced only small physiologic effects and mild sedation, it significantly reduced the pressor (increasing blood pressure) response to cocaine and the increase in pupil size produced by cocaine, and nearly eliminated the decrease in skin temperature produced by cocaine. While none of the subjects reported the combination improved the euphoric mood produced by cocaine, they did report fewer cocaine-associated side effects, such as shakiness. While cautioning about drawing too many conclusions from a study in which two drugs are given sequentially, the researchers said the drug "warrants further consideration in the treatment of depression in those patients who may be using cocaine."

Annals of General Psychiatry, Sept 1984, v.41:895-899

Liver biopsy as cirrhosis predictor

A liver biopsy is a better way of predicting which alcoholics will develop cirrhosis than a record of the patient's drinking history, a Danish study has concluded. Between 1968 and 1971, 258 alcoholic men in the study were given an initial assessment, including a liver biopsy. The men, free of the disease initially, were then followed until March 1981, a period of 10 to 13 years, to see who developed cirrhosis of the liver. Researchers from the Copenhagen City Hospital and Hvidovre University Hospital, Copenhagen, found that 14.7% of the study group developed cirrhosis. The incidence of cirrhosis was not found to be significantly related to the duration of the preceding alcohol abuse, the average daily consumption of alcohol, or the preferred type of alcohol, as reported during the initial examination. But the researchers found that liver function tests such as plasma bilirubin, aspartate aminotransferase, and bromosulphthalein retention, as measured at the initial examination, were all significantly higher in patients who later contracted cirrhosis. Steatosis, lipogranuloma, alcoholic hyalin, and inflammation of the lobules and portal spaces, as found on the initial biopsy, were all predictive of the development of the disease.

The Lancet, Aug 4, 1984, no 8397:241-244

Smoking and taste perception

The common belief that smoking dulls taste perception has been shown, in large part, to be a myth. Kathleen Redington, department of neurology, division of cognitive neuroscience, Cornell Medical College, New York, compared taste differences among cigarette smokers who were allowed to smoke, smokers not allowed to smoke prior to the tests, and non-smokers. Each of the subjects rated the pleasantness and intensity of sugar, salt, and quinine solutions, before and after the ingestion of a glucose solution. She found that all three groups perceived the intensity of the various solutions similarly. She concluded "smoking or nicotine *per se* does not affect the perceived intensity of sweet, salty, or bitter tastes." But, after consumption of the glucose drink the perception of those smokers who were allowed to continue smoking until the experiment began not only found sweet tastes significantly less pleasant than non-smokers but also rated it as less pleasant than when they had not been smoking prior to the test. From this she concluded that "there is a relationship between cigarette smoking, glucose consumption, and a liking for sweet tastes," although the mechanism for this is unclear.

Pharmacology Biochemistry and Behavior, Aug 1984, v.21:203-208

Benzodiazepines and the elderly

A review of benzodiazepine use in a group of elderly patients indicates prolonged use, at low doses, appears not to be harmful. The study population consisted of 93 patients aged 55 years or more who used the ambulatory medical service at Beth Israel Medical Centre, New York, and had received at least two prescriptions for the benzodiazepines diazepam, lorazepam, or chlordiazepoxide. This group was interviewed about various aspects of their drug use by Henry Pinsker, MD, and Kasja Suljaga-Petchel, MD, of Mount Sinai School of Medicine, NY. The patients (almost 80% female) reported that the medication calmed them, relieved tension, and helped them sleep, while light-headedness and sedation were the most commonly reported side-effects. One-third of the subjects both in the continuing user and former user group admitted they were afraid of becoming addicted to the medication. None reported increasing the dose of the drug they used. However, the majority reported keeping a supply of the drug at home "to be used when the need arose." The researchers concluded while the risk of over-medication or addiction may be real, "our study suggests that addiction to diazepam is exceedingly rare."

Journal of the American Geriatric Society, Aug 1984, v.32:595-597

Pat Rich

Vancouver MD to stand trial on controlled drug charge

By Tim Padmore

VANCOUVER — A doctor here has been ordered to stand trial for prescribing a controlled drug to an undercover police officer.

During the preliminary hearing that preceded the order, evidence was given that Kenneth Varnam, MD, gave the officer a prescription for Tenuate (diethylpropion) without conducting a physical examination.

Constable Kenneth Cardinal testified that he came to Dr Varnam's office posing as a bisexual street person.

Well-known in British Columbia, Dr Varnam is a director of the British Columbia Medical Association (BCMA), and chairman of the BCMA's drug dependency committee.

Constable Cardinal said he told the physician that he wanted a prescription for Ritalin (methylphenidate) to stay awake, that the drug sold for $5 to $10 a tablet on the street, and that he wanted a prescription to get around pushers and the police.

The officer was carrying a recording device and a transcript of the conversation was entered in evidence, including Dr Varnam's reply that Ritalin is tightly restricted but that he would be willing to give him Tenuate instead.

"I'll give you a prescription for something which is probably the best, as far as — or next best — to Ritalin, as far as anything that's available, as far as keeping you awake and so on," he is reported to have said.

The officer testified he did not feign or gesture any medical problem and the doctor gave him a prescription without taking a medical history or making a physical examination.

James Kennedy, PhD, a clinical pharmacologist at St Paul's Hospital here, testified that Tenuate is approved in Canada only for controlling obesity and that there are a number of contraindications for prescribing the drug. He said that, on the basis of the transcript, Dr Varnam had insufficient information to start prescribing treatment.

Dr Varnam's attorney, Sid Simons, argued that the slim undercover officer appeared to the doctor to have a social need for the drug, and that Tenuate was selected in part because it has less abuse potential than Ritalin, which has an easily dissolved component that can be conveniently injected.

Mr Simons said Dr Kennedy was dogmatically citing the formal recommendations for use of the drug and that it is up to individual doctors to decide whether a controlled drug is required for treatment.

He also argued that the prescription did not constitute "trafficking."

However, Judge L. W. Smith decided there was sufficient evidence to bring Dr Varnam to trial on the two charges of trafficking and administering a controlled drug, laid under the Food and Drugs Act.

(Six other doctors, also charged with trafficking in a number of prescription drugs, will be dealt with separately [**The Journal**, July].)

The judge went to the dictionary to deal with the question as to whether prescribing constitutes trafficking.

According to the Act, one of the meanings of traffic is "sell," and one of the meanings of sell is "distribute." The Oxford dictionary defines distribute as "to deal out or bestow, to allot or apportion, to dispense."

He ruled that Dr Varnam's actions fall within the sphere of the Act, and that the undercover officer did not require the drug for any condition for which he was seeking treatment.

'Save young people one at a time'

Reagan passes Sultan's gift on

By Harvey McConnell

WASHINGTON — A donation of $500,000 has been made by the Sultan of Brunei, through United States First Lady Nancy Reagan, to the National Federation of Parents for Drug-Free Youth (NFP).

Mrs Reagan made the gift by the leader of the tiny independent nation on the island of Borneo to ecstatic NFP leaders and delegates at the third annual conference here of the anti-drug organization.

Mrs Reagan met the Sultan during a visit with President Reagan to the United Nations. In a letter accompanying the cheque, the Sultan said Mrs Reagan's efforts in fighting drug abuse were important to the world community, and she is helping people understand "the consequences of a life thrown away, how precious life is, and what each individual has to contribute."

She told the conference she is often asked how anyone could keep going "when the statistics on drug and alcohol abuse, and the wreckage of families that those numbers represent, keep coming like an avalanche."

Reagan

The aim is a drug-free society, but the way to get there is by saving young people one at a time. "That's the spirit that keeps us all going," Mrs Reagan said.

ADAMHA's Sobell verdict in

By Karin Maltby

TORONTO — A United States government investigation of allegations of scientific misconduct by two alcoholism researchers has ended without reaching definitive conclusions.

"Because complete information was not available from either the persons making the allegations or the subjects of these allegations, it was not possible to reach definitive conclusions," states a memorandum to the administrator of the US Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). The memo accompanied the August release of a report entitled: *Report of the Steering Group to the Administrator, ADAMHA, regarding its attempts to investigate allegations of scientific misconduct concerning Drs Mark and Linda Sobell.*

While expressing caution concerning its observations, the ADAMHA Steering Group report states that: "Based on the investigative team's necessarily limited review, the Steering Group did not find evidence to demonstrate fabrication or falsification of data reported by the Sobells. However, we did note some errors and use of ambiguous terminology in their publications which indicate to us that the Sobells were careless in preparing their manuscripts for publication."

The allegations against the Sobells (both PhDs) were made by Mary Pendery, PhD, *et al* in a July 1982 article in *Science*. The article challenged the early, 1970s controlled-drinking research conducted by the husband-and-wife team at a California state hospital. The research was partially funded by the US National Institute on Alcohol Abuse and Alcoholism.

The Steering Group said Dr Pendery and co-author Irving Maltzman, PhD, did not submit documentation to support their allegations despite repeated requests, although they did meet with the Steering Group.

Investigative team members met also with the Sobells and had "free access to the Sobells' data" on two occasions. In March, however, the Sobells' attorney wrote the Steering Group that "making detailed notes on the Sobells' files, if permitted to continue, might seriously jeopardize the Sobells' interests in connection with pending and potential litigation against them."

The Aug 17 memo to ADAMHA administrator Ian Macdonald, MD, from deputy administrator and Steering Group chairman Robert Trachtenberg, noted that the Steering Group was not charged with addressing the merits of controlled drinking: "Questions concerning this issue cannot be resolved by looking at any single study." But, he quoted a 1983 report to US Congress which states that "the most appropriate goal for alcoholic persons is abstinence."

This latest judgment of the Sobells' work follows a 1982 review by a prestigious Canadian review committee which found "no reasonable cause" to doubt the scientific or personal integrity of the Sobells. The review committee was assembled through the Addiction Research Foundation of Ontario here where the Sobells have been employed since 1980.

In 1983, a researcher from a US Congress subcommittee also found no evidence to support allegations that the Sobells had falsified data.

The memo made two recommendations: that the report be circulated, and that "if ADAMHA receives a grant application or contract proposal in the next two years from the Sobells, the (Steering Group) report should be made available to persons considering the application or proposal."

NEWS AND COMMENT

Recession may curb effects of 'easy living'

Israel facing alarming rise in drunk driving

By Michael Kesse

JERUSALEM — Drunk driving has become an important factor in Israel as a cause of traffic deaths among both Jewish drivers and Jewish pedestrians.

"Our reputation as non-drinkers is rapidly disappearing," Elihu Richter, of the Hebrew University, said here at the International Congress on Alcohol Dependence, the Family and the Community. Dr Richter was reporting on the preliminary results of a research project covering the five years 1976 to 1980.

Colonel Eytan Ben-Yehoshua, head of the Israeli Police Traffic Division, not only concurred, but also noted that "if, in 1975, zero accidents were caused by driving while intoxicated (DWI), the figure jumped to three in 1977; to 38 in 1978; to 58 in 1983, and, during the first six months of the current year, 1984, we already have had 70 such DWI accidents. We are being hit by an epidemic."

He noted that in many cases DWI had never been suspected — "since it had been so rare in the past."

The Israeli Police recently purchased 100 breath-testing machines which will soon be put to use. Although Israel has one of the highest traffic accident rates in the world, a decade ago few accidents were caused by drunk driving.

Dr Richter said an estimated 14% of all driver deaths in the five-year period, and about 13.4% of all pedestrian deaths, were attributed to drinking.

The study was based on samples of blood alcohol concentration (BAC) with 0.05% being considered by Dr Richter as the "threshold of the impairment of reactions."

The sample consisted of 36.4% of all fatally-injured drivers and 31.2% of all pedestrians killed in the five-year period.

"We could not take blood samples from all those killed, since some families objected on religious or other grounds. Nevertheless, I am confident that this sample is quite representative," Dr Richter said.

Of the 257 fatally-injured drivers, 36 (14%) had a BAC of 0.05% or more; and of the 313 pedestrians killed, 42 (13.4%) had a BAC of 0.05% or more.

The percentages of deaths were much higher during the night, ie, from 10 pm to 5 am. Of the 29 drivers killed during these seven hours, 16 (55.2%) had a 0.05% BAC or more, and of the 27 pedestrians, 16 (59.3%) had a BAC of 0.05% or more.

Although Christian drivers accounted for about 6% of all deaths (both as drivers and pedestrians), their "drinking-death" ratio was the highest, 21%. Moslems accounted for 16% of all deaths, with a "drinking-death" ratio of 18%, while Jews accounted for 78% of all deaths, with a "drinking-death" ratio of 17%.

(Contrary to many reports, Moslems [ie, non-orthodox Moslems] drink hard liquor, generally arak, an anise-flavored, white drink, with an alcohol content of 40% to 50%.)

Three times as many DWI drivers were killed in one-car accidents as in two-car accidents. And, there was a high percentage of people 18 to 25 years among those DWI. While none of the female drivers who died had been drinking, among pedestrians killed an almost equal number of men and women had been drinking.

"There is a definite relationship between the feeling of economic affluence in Israel and DWI," Dr Richter said. He said there was a sharp drop in DWI accidents during the "belt-tightening" administration of Finance Minister Yigael Hurvitz in 1980, and an upsurge during the "easy-living days" of Finance Minister Yoram Aridor (1981 through most of 1983).

Since Israel is now moving into a recession, the incidence of deaths of intoxicated drivers may be expected to drop.

"However, we no longer have the tools to determine if this is so, since the new Autopsy Law, passed by the Orthodox Jewish Parties and which makes it difficult to carry out post mortems, may blur the magnitude of the picture. This will help keep the problem under wraps — with a resulting rise in deaths," Dr Richter said. And he added: "Make sure you quote me on this."

Teen market being tapped by US cocaine traffickers

By Harvey McConnell

WASHINGTON — Cut prices and new paraphernalia are being used by cocaine dealers to increase the adolescent market.

One of the newest gimmicks — hollowed out, bullet-shaped objects for sticking in the belt — is being widely distributed around the country, says Mark Gold, MD, director of research at Fair Oaks Hospital, Summit Hill, New Jersey, and a founder of the 800-CO-CAINE hotline.

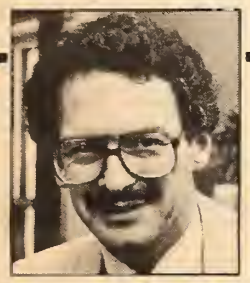
He told the annual conference here of the National Federation of Parents for Drug-Free Youth that many of the rich have dropped out of the cocaine market because they have learned what cocaine can do.

"And the middle class are now being burned and they are learning first hand." But cocaine dealers are searching for a new market and have found one: adolescents.

Dr Gold said calls from adolescents now make up 20% of the average 1,250 calls to the helpline each day. The helpline has reached the 600,000-call mark since its inception in May 1983 (**The Journal**, May 1984, July 1983).

Dr Gold said they find adolescents "have almost instantaneous problems" at school and home when they start using the drug. Within six months, most are engaged in "stealing, setting their homes up for robbery, distributing and dealing, and with some sexual barter involved."

GILBERT



'. . . . two ways in which Ledermann's notions might be given new life . . .'

Patterns of drug consumption

By Richard Gilbert

The United States National Institute on Drug Abuse (NIDA) and the US National Institute on Alcohol Abuse and Alcoholism (NIAAA) held a two-day conference at the National Institutes of Health campus, Bethesda, Maryland in early October. The subject was "An examination of the distribution of consumption of selected dependence-producing drugs."

Dr Robin Room of the University of California and I were the conference's two discussants. We were to comment on and synthesize what was said during the meeting. My invitation came, I believe, as a result of related things I had written in these columns.

The conference had two aims. The first was to assess the standing of the Ledermann model of the distribution of alcohol consumption. The second was to determine whether the Ledermann model has application to the use of other drugs, specifically amphetamines, cocaine, and marijuana.

The 13 participants were flown in from as far away as Finland (Dr Klaus Mäkela of the Finnish Foundation for Alcohol Studies) and Australia (Dr Simon de Burgh of the University of Sydney). Six NIDA and NIAAA staff also participated, crowding a small meeting room that reflected what John Kenneth Galbraith might describe as a new age of public squalor.

The first of the two volumes of Sully Ledermann's influential book *Alcool, Alcoolisme, Alcoolisation* was published in Paris in 1956. Ledermann looked at how many drinkers were consuming different amounts of alcohol in various jurisdictions in France. He concluded that the alcohol consumption of drinkers in any population can be described by a mathematical relationship known as the lognormal distribution.

What this means, in effect, is that a graph with "number of drinks per day" as its horizontal axis and "number of drinkers at each level of consumption" as its vertical axis will have the shape of an upside-down U with the peak pushed over to the left and a long tail drawn out to the right. The curve for alcohol shown in the top graph on the right gives the idea.

The chief implication of Ledermann's model of alcohol consumption is that the proportion of alcohol abusers in a population (ie, those drinking more than a defined amount) is related to the average consumption for the whole population.

It follows that measures designed to reduce overall consumption will also reduce consumption by heavy drinkers. Indeed, the effect on heavy drinkers will be proportionately large according to their use of alcohol.

Enthusiasts of Ledermann's work go further and say that the only way to reduce the amount of heavy drinking is to reduce, on average, everyone's consumption of alcohol. Measures such as tax increases, which affect every drinker, will be more effective than measures such as draconian penalties for public drunkenness, which affect only heavy drinkers (and then only some of them).

Both critics of and apologists for Ledermann were present at the conference. The critics agreed that Ledermann had been correct and helpful in pointing out the general nature of the distribution of alcohol consumption, but he had been "reckless" in assuming it to be universally lognormal.

So flimsy were the data available to Ledermann, he was said to have engaged in "extravagant thinking" and undergone a "hygienic conversion" to the validity of his law. Dr de Burgh asked at the conference whether scientists at Ontario's Addiction Research Foundation in the 1970s had also experienced such a conversion when they became advocates of the view that only population-wide measures are likely to be successful in combatting alcohol abuse —a view I have espoused in these columns.

What became clear to me in Bethesda is that arguments as to the validity of Ledermann's notions about alcohol use have become sterile. Little progress has been made toward resolving the question as to whether *only* population-wide measures can be effective in reducing alcohol abuse.

It was, in retrospect, unwise of the NIDA to think that this line of research on alcohol use might have something useful to offer for those concerned about amphetamines, cocaine, and marijuana. If NIDA officials had anticipated the debate that is Ledermann's legacy, they might very well have invited economists or clerics instead to give them inspiration.

Even if Ledermann's views were uncontroversial, there would be good reason to question their application to the use of illegal drugs used by a minority of the population. Ledermann's notions were developed for what, in France in the 1950s, was all but universal behavior, deeply rooted in everyday culture. It seems a far leap to apply them to the relatively rare and socially unacceptable activities of illicit drug use.

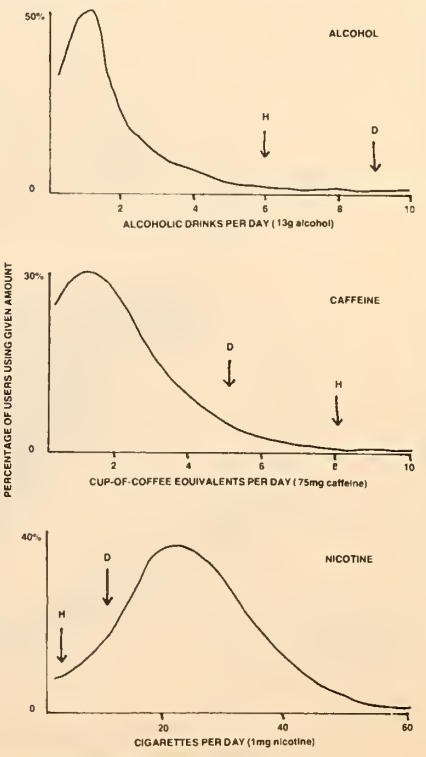
Moreover, the central question around Ledermann's theory is not relevant to the consumption of illegal drugs. Society is not concerned with whether it is better to curb cocaine consumption by hitting all cocaine users or just those who use a lot of the drug.

In my discussion of the conference proceedings I suggested two ways in which Ledermann's notions might be given new life.

The first is to examine the distributions of the consumption of other "popular" drugs, caffeine and nicotine in particular. The graphs show alcohol and caffeine use data from the Ontario Drinking Study, in which the beverage consumption of a cross-section of Ontario's adults was determined in 1969. Examination of the similarities and differences between the two distributions might provide insights into how each distribution comes about. The few data we have suggest that the levels of consumption causing hazard (H) and physical dependence (D) are differently located in the distributions. It would be of interest to know how other features of the distributions might be related to these differences. Caffeine consumption, especially in the US, is undergoing considerable change, providing good opportunities for examining the dynamic features of distributions that are broadly similar to those for alcohol consumption.

The third graph is based on data for Canadian male smokers aged 24 to 64 years from the Canadian Health Survey (1978-79). This distribution in itself is evidence that all drug use does not obviously follow the pattern of alcohol. Also, unlike alcohol and caffeine, most users are harmed by and dependent on the drug.

My second suggestion to the conference was that Ledermann's notions be applied to achieving the optimum level of average alcohol consumption by a population, given the evidence that moderate use may be beneficial. I did this in a primitive way in two earlier columns (**The Journal**, Dec 1983 and Jan 1984). I'll return to this question next month.



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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Adult kids of alcoholics have treatment advantage

Further to the special section in **The Journal** (Oct) on children of alcoholics — Families and alcohol: A legacy of love and pain — I would like to share what I consider to be interesting findings on the response to treatment by this population.

In a study conducted at the Addiction Research Foundation to examine the appropriateness of abstinence and moderation as goals for early-stage problem drinkers (**The Journal**, April 1983), the children of alcoholics in the study drank substantially less after discharge than did their counterparts who did not have an alcoholic parent.

At six months, 12 months, 18 months, and 24 months following treatment, the children of alcoholics drank as much as their counterparts on each drinking day (about four drinks). However, they drank on significantly fewer days. Overall their weekly consumption was about half the amount.

Of the 70 subjects treated, 28 or 40% had an alcoholic parent.

In both groups, the interval between the inception of regular drinking and the onset of problem drinking was approximately the same. At intake, both groups were also similar in age, years of education, income, percentage working full-time, and measures of liver and cognitive functioning. Both groups reported an average of five years of problem drinking and similar patterns of alcohol use (ie, quantity and frequency).

In treatment, the drinking behavior of the two groups was comparable. It was following treatment that those who had an alcoholic parent were shown to be drinking significantly less.

This finding is particularly interesting as children of alcoholics might be considered to have a poorer prognosis for treatment success. Results from our study, at least, suggest they may in fact benefit more from treatment than problem drinkers without a family history of alcoholism.

One could speculate that witnessing the consequences of drinking in a parent may increase the motivation to maintain drinking at very moderate levels.

I should point out that familial alcoholism was not a research question during the study. Some time after the completion of the research, the question of treatment success in this group was broached and the data were re-examined for this variable.

Other researchers who've worked on early-stage problem drinking may want to see if their data show similar trends.

Martha Sanchez-Craig, PhD
Behavioral Research Dept
Addiction Research Foundation
Toronto, Ontario

Reader finds articles healing

Please enter my name and address on your subscription files. I've just finished looking at the October issue of The Journal and have found the articles on adult children of alcoholics — Families and alcohol: A legacy of love and pain — informative. More importantly, however, it was 'healing' to continue to find that I am not alone in trying to understand these very personal issues.

George W. Kaczanowski
MacMillan House
Barrie, Ontario

Early education tool of great value to kids

I am a drug and alcohol abuse worker in Scanterbury, Manitoba.

In regard to the article, Auto club kit helps kids make alcohol decisions (**The Journal**, Sept), I would like to get some more information on how to obtain and purchase this kit.

I believe it would be of great value to us as we are attempting to educate our children as early as possible about alcohol and other drug abuse. Your help would be greatly appreciated.

I enjoyed the article and the information it provided.

Carl N. Olson
Brokenhead Indian Band
Scanterbury, Manitoba

Editor's note: For more information, contact: Patricia Curran, Canadian Automobile Association, 2 Carlton St, Toronto, Ontario M5B 1K4. The telephone number is (416) 964-3170.

More on 'Tuning In' kit

The article, Students playing games to learn drug risks, in the September issue of **The Journal**, was interesting.

Tuning In To Health, the program described in the article and developed by the Alcoholism Foundation of Manitoba, sounds very beneficial.

The staff of Spooner Memorial School would like to get more information and a cost estimate for the program.

Please send the address and any other information at your earliest convenience.

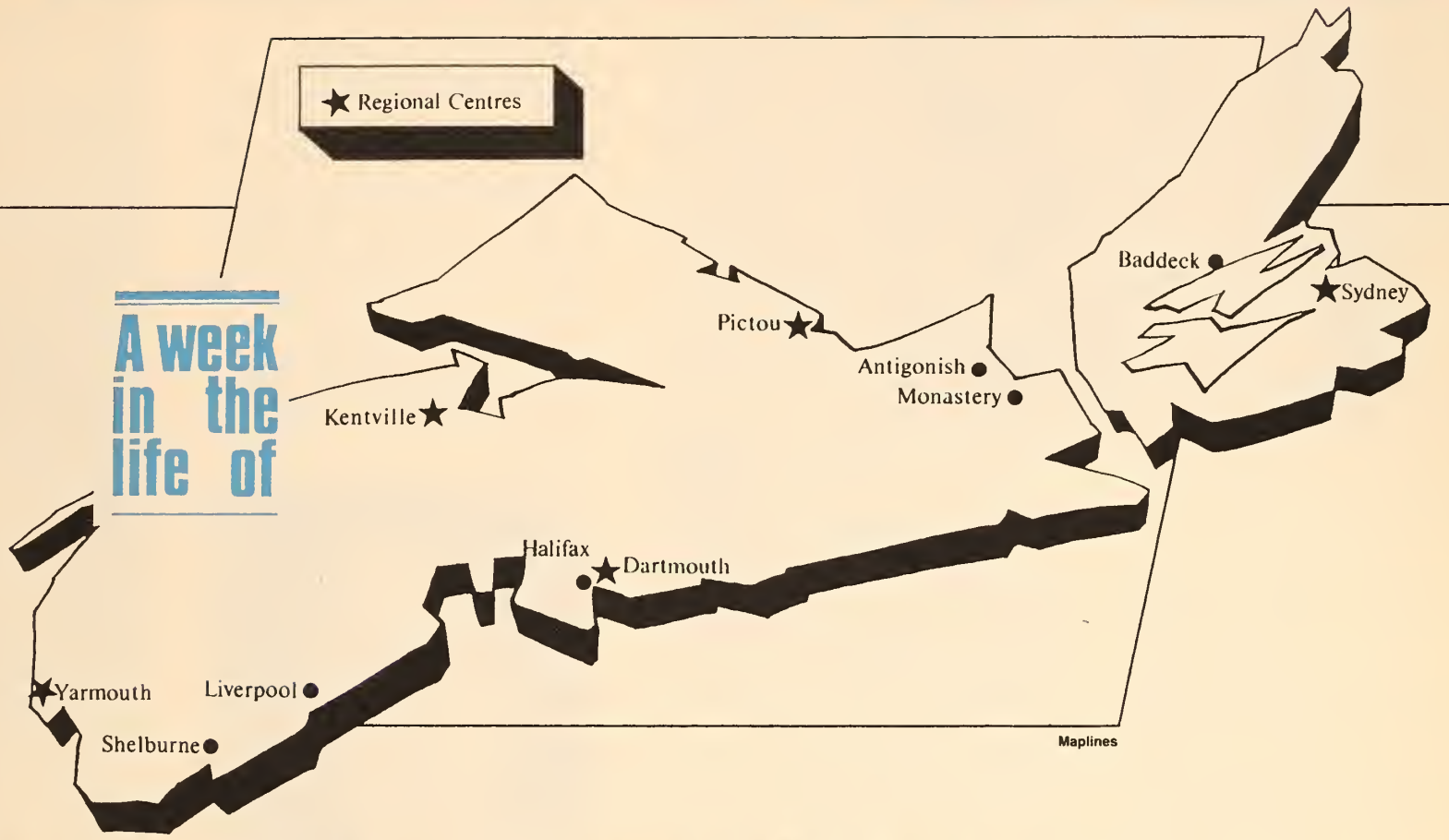
W. H. McLenaghan
Principal
Spooner Memorial School
Smiths Falls, Ontario

Editor's note: For further information on the Tuning In To Health program write — Alcoholism Foundation of Manitoba, 1041 Portage Avenue, Winnipeg, Manitoba R3G 0R8.

A week in the life — Nova Scotia

The first of an occasional, in-depth look at people and programs in the Canadian addictions field.

The Journal DIARY



THE NOVA SCOTIA COMMISSION ON DRUG DEPENDENCY

Anne MacLennan reports from Nova Scotia

HALIFAX — First clue. At the head table, the premier of the province and the health minister are playing verbal tennis with local humor as the ball. The executive director of the provincial Commission on Drug Dependency, also at head table, referees.

It's good old Nova Scotia fun for them and for more than 600 addictions workers at the closing banquet of the spring meeting here of the Canadian Addictions Foundation, Atlantic region.

For some, it's also enviable, this "team spirit," this nearness to political power.

Second clue. A few months later at a service station on a country highway, far from Halifax and the head office of the Nova Scotia commission, Marvin Burke, executive director and conference master-planner, pulls in for gasoline.

"You down here workin' Mr Burke?" asks the attendant.

The executive director doesn't know the man and doesn't recall having stopped here before. But he isn't surprised; this happens.

"He may be in AA (Alcoholics Anonymous) and know our work. Or maybe he knows somebody on the local committee. Or maybe . . . ," says Mr Burke.

A disadvantage — minor: it's hard for the executive director to take a real holiday in Nova Scotia.

An advantage? It's even harder to argue with a community base that calls the man from head office one of its own.

On the one hand, power. On the other hand, power. Both hands pointing to political survival and success for the Nova Scotia commission.

Mr Burke bridles slightly at the suggestion he's a link man between citizens and government. Lynchpin? No better. But it's there. At the office, in the car, day and night. "Must make a note for the agenda with the minister."

Or, at a regional centre: "Hi kid. Howya doin?"

"Hi Marvin."

He talks frequently about the partnership of citizens and government. And he refers to it again and again in papers and speeches and presentations — at home in Nova Scotia, in other provinces, abroad.

This is how he put it to the 2nd Pan Pacific Conference on Drugs and Alcohol in Hong Kong about a year ago:

"In effect, the commission has developed a partnership with citizens. This partnership is complex; each partner has rights and responsibilities.

"The government is responsible for the provision of services and infrastructure for those who require assistance.

"Active and concerned citizens are responsible for identifying the problems in their community, outlining the resources available and/or required, and supporting these resources by becoming well-versed in the specifics of the problems.

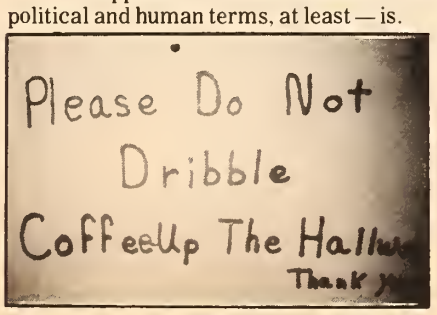
"Citizens and government share equally the responsibility for raising the level of public awareness and for developing the messages which may inform and educate. This approach can be effective for many health and social problems."

The thinking is grounded in the belief that services are of no use unless they can be delivered to those who require them.

Says Mr Burke: "Decentralization of services through regional and district offices is only partially effective. All too often, the actual and potential clientele, and the community at large, tend to feel isolated from these services.

"They perceive them as a bureaucratic maze of policies and regulations . . . potentially blocking effective response to the community's needs. This may limit the effectiveness of a government human service agency."

The belief that services are for those who require them is hardly unusual. But, the approach Nova Scotia has taken to involve the community, and the extent to which it appears to have succeeded — in political and human terms, at least — is.



Pictou: a familiar treatment centre plea

If the premier, the health minister, and the executive director, in that order, are at the top of the pyramid with their fingers to the political winds, people from towns and villages across the province form the pyramid's immoveable base. They are local people, familiar with local needs, and sitting on local committees on drug dependence — "partners in government."

In the five regions through which the commission delivers its services, the local committees are the front-line scouts — checking on needs and problems, making proposals and recommendations, and often actively working at education and prevention — in league with field representatives from regional centres, and always with basic training from commission staff. Sometimes, but not always, they are people who've recovered from alcoholism or other drug dependence.

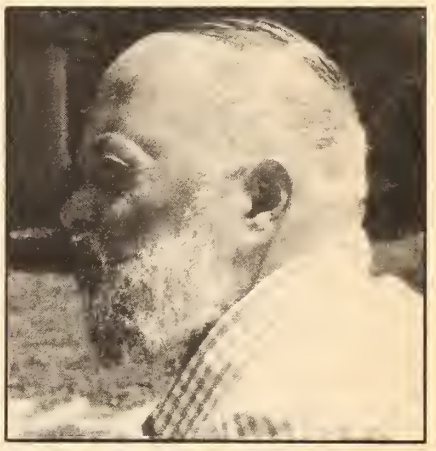
Five regions, five regional program offices, five regional advisory boards, and 500 community people working on 33 local committees. From the local committee, a representative goes to the regional advisory board (appointed by the commission). And from the regional board, a representative goes to the commission board itself.

The connection's complete — community interests get translated outwards and upwards. Meanwhile, in town and village, the volunteers are a tremendous human resource.

In 1982-83, volunteer committee members logged more than 10,000 hours on commission work. Based on funds given to local comittees for special events and resources (from $150 to $2,000), the cost to the public per volunteer hour was 83 cents.

As for program delivery to the communities, central office in Halifax provides coordination and policy back-up province-wide in four main areas — treatment and rehabilitation, employee assistance programs, community education and prevention, and research and evaluation. Staff also includes resource people in such areas as youth and schools, library and information services, and pharmacology, as well as administrative support.

Each of the five regions has a centralized treatment unit and outpatient office — in Sydney for Cape Breton region; Pictou for North Shore; Dartmouth for Metropolitan/Lunenburg; and Yarmouth for Western region. The Valley region is operated



Burke: complex partnership

under the suspices of the Valley Health Services Association; its central treatment centre and outpatient office is in Kentville. The commission also operates satellite, outpatient follow-up centres.

Regional offices are directed by regional coordinators who report directly to the executive director. Regional staffs, in turn, include managers of treatment services, field representatives who liaise closely with local committees, research assistants, and office managers.

Treatment staff includes nurse rehabilitation counsellors, counsellor attendants, community health workers (frequently recovered drug-dependent people with five years of stability), and clinical therapists (Master's degrees).

The net's in place and the consensus in Nova Scotia is that they're on the right track for getting the right services to the right people at the right time.

Those without such obvious proximity — either to the community or the political power — can take some comfort in the fact that Nova Scotia is not large. With a population of about 860,000, it's smaller than many cities in other parts of North America and elsewhere.

Nevertheless, as Mr Burke has noted: Nova Scotia has done "exactly what was recommended by the World Health Organization (June 1981); it has 'tailored solutions to alcohol-related problems to local circumstances.' This approach may very well be used in other states."

A Week in the Life ——→

The Journal

Father MacDonald with MacLennan: if GM can do it . . .

MONDAY

9:30 am
Talbot House, Frenchvale
Cape Breton Island

The farm is lush in the morning sunshine. One man works the garden near the duck pond; others are at chores in the sheds and barns. And Bernie MacDonald, in worn jeans, heavy boots, and a T-shirt, emerges from the house, extending a strong, worker's hand.

He has studied in Canada and the United States and taught (mainly history and English) in North America, Hong Kong, and Tanzania. Today, as every day now, he was up at 5 am to help with the milking and begin another 24-hour day as priest, working farmer, therapist and counsellor, business administrator, head gardener, and entrepreneur.

A native Cape Bretonner — his family's farm is just across the island — Father MacDonald is a member of the Maryknoll Fathers, a dwindling order of missionaries whose parish may be almost any spot on earth.

For the past 10 years, he's been director of Talbot House, one of two long-term shelters for recovering alcoholics and addicts in Nova Scotia, both on Cape Breton Island.

Although no one is ever turned away, there are beds for about 30 men. (Mr Burke and Wayne Yorke, the commission's regional coordinator for Cape Breton, are hinting they'd like to try adding some female patients — only the staff now includes women. Father MacDonald himself is not keen, believing the mix would disrupt.)

Father MacDonald's chief concern is for the welfare — physical and emotional — of his patients, who usually stay five or six months, though some remain a year or more. His close second concern is the need to keep the $225,000 per annum operation viable.

On the therapeutic side, he expects the men to adjust to (he says they usually do), and benefit from, community living. They are held responsible for themselves and each other, participate in regular group therapy and discussions, and are given relaxation therapy. "If General Motors can do it for their executives, we can do it for our patients," says Father MacDonald.

Not one to overlook therapeutic possibilities, he added some new stock to the farmyard this summer — Highland Cattle. The long-haired, long-horned animals are considered people loving. "Alienated people can reach out to an animal and get a positive response. These cattle receive and show affection easily," he says.

"But, these are not just games, it's work," he adds. Patients are responsible for the upkeep and smooth running of the house, the farm, and its various associated enterprises. It makes the colony "relatively self-sufficient."

With chickens (and eggs), turkeys, pigs, dairy cattle, and vegetable gardens, the men produce, live on, and even sell some of their wares.

In the carpentry shops, they build crêches to sell in the community at Christmas. Recently, they have begun making, and finding a market for, grave markers — simple, carved, metal nameplates which are pinned on to concrete blocks.

In his small office, near the kitchen and a huge woodfire stove throwing out a blanket of heat and the aroma of baking scones, Father MacDonald sits within easy reach of the medical dictionaries and reference books he had in the seminary. And he recalls and borrows for his own the view of Julius Nyerere, founder and first president of Tanzania: people and communities of people must rely upon themselves.

"The more independence we have here, the better," he says and means, among other things, independence from government.

Grateful for the $85,000 annual grant from the commission, he says half of it is recoverable from the federal government for health care. "It's costing the government about $4.50 a day (net per patient) to run Talbot House. Jail would cost $100 a day and hospital, $300." The men, and Father MacDonald, recover the remainder with their marketing schemes and donations, and with help from the church.

Today, as soon as his visitors leave, Father MacDonald is taking his first holiday for many months — an afternoon at his family's farm. He'll be back tonight and up at 5 am tomorrow morning to help with the milking.

11 am
Northside General Hospital
North Sydney

The hospital is in a turmoil of renovation, but here, down a hallway and under a light covering of plaster dust, is one of 28 satellite (and central) outpatient units of the commission in the province.

Here too is Mary MacIsaac, a registered nurse in charge of the hospital's diabetic clinic. She is also a member of the commission's regional advisory board for Cape Breton Island. On holidays is Garnet Marsh, community health worker, who generally operates from the centre.

Having seen about 32 diabetic patients already today, and expecting another 20 or so, Mrs MacIsaac is ready for a coffee with the man from central office and his Ontario visitors. Mrs MacIsaac greets Mr Burke as a long, firm friend. She appears to know not only every diabetic, but also everybody else — or at least the families of everybody else — within a radius of a few hundred square kilometres.

It's a short, get-acquainted visit (we'll all meet later for dinner). But, the point is made.

Says a background document: "Decentralization was achieved by the creation of five regional advisory boards. Board members represent regional communities in which they live and for which they are responsible . . . (their mandate) is to review programs which have received approval, funding, and implementation in the area, and to advise the commission on such programs regarding community perspectives and the need for programs which may be offered to deal with drug dependency."

After a quick tour of the hospital, and a short visit with hospital administrator Armand LeBlanc, who also apologizes for the plaster dust but is equally gracious in his welcome, Mrs MacIsaac gets back to her patients.

As others would attest through the week, Cape Bretonners reckon if they're lucky to work here, they're blessed to be able to holiday here. As we leave, Mary is planning some time off — down the highway for a few kilometres to her favorite place in the world.

MacIsaac: advising the commission

12 noon
Sydney

The faded sign over the door reads Little Flower House. But a newer, more prominent one says Cape Breton Addiction/Rehabilitation Centre — a regional service of the commission serving the residents of four counties — Richmond, Victoria, Inverness, and Cape Breton.

Treatment and rehabilitation programs in all five regions of the commission are generally three-phased: Primary care — detox, assessment, and treatment orientation (usually a five-day education program focusing on the here and now, and linking people to follow-up and after-care services); after-care — a 28-day inpatient treatment program; and central or satellite outpatient services. These are aimed at helping people to learn more about alcoholism and other drug dependencies; "realize, face, and take" responsibility for the effects of their drug dependency; learn more about themselves and how to cope; and "put together a healthy, productive sobriety or drug-free state."

"These aims," says the commission, "can be achieved through such program areas as a client lecture series, group discussions, individual counselling, family lectures and counselling, creative and physical therapy, employer interviews, exposure to self-help groups, such as AA, and generally an atmosphere supportive to self-examination for growth and change."

With that as a base, Wayne Yorke, regional coordinator, operates his program — 10 detox beds, 10 treatment and orientation beds, and 13 residential rehabilitation program beds, as well as eight satellite out-patient centres (including the one at Northside Hospital), a half-way house, and two long-term sheltered workshops, Gillis House, with 10 beds, and Talbot House (above).

The units, with only minor variations, could be anywhere in the world. So could most of the problems and some of the questions.

In the midst of a self-help and treatment-dominated discussion, for example, head nurse and rehabilitation counsellor Dorothy Morrison gets a word in for research. It may be expensive, it may appear obscure or unpopular. But, if there is an answer to the problems of alcoholism, part of it must be found in research, she says.

Pragmatically, counters field representative Allister MacRae, self-help groups and community support are what get people over the hurdles.

For today, though, Mr MacRae's chief interest is in a group of teenagers he's got working on a special project. They're translating some literature on alcohol and other drugs into a language they and people at community level can understand easily.

Burke and Yorke at Talbot House: adjusting to community living

Context

Nova Scotia, a peninsula, clings to Canada by a thread running from it into New Brunswick to the north west. The two provinces, with Prince Edward Island tucked between, and Newfoundland/Labrador to the north/north east, make up the Atlantic provinces of Canada — "down home," as it remains to easterners who fan across the continent to jobs and "homes away."

Most Nova Scotians are of British, particularly Scottish, origin. And the links linger on — in accents, values, place names and family names, even in food.

Running British ancestry a close second is French, followed by German and Dutch. Racial minorities include Blacks, some of them descendants of survivors of the Underground Railroad from the United States, and native Indians of the Micmac tribe, who, in the 1700s, helped the French against the British. Today, their descendants are settled in five reserves through the province.

More than half of Nova Scotians live in cities — the three major ones being Halifax, Dartmouth, and Sydney. About 378,500 (28%) are in the work force. Professional, managerial, and administrative occupations make up 23% of all employed people. Primary occupations, such as fishing and lumbering, employ 6.1%, and clerical, sales, and service occupations total 42.4%. The rest, about 28.5%, are in construction, transportation, and other craft occupations.

At F scer this and

2 pm

Cape Breton Island, says a tourist brochure, is one of the oldest European place names in North America. In 1497, John Cabot is said to have landed on these shores. When Shakespeare was writing, French, British, Spanish, and Portuguese fishermen sailed in Cape Breton's harbors. In the 18th century, it was the site of one of the greatest fortresses in North America — the now restored Fort Louisbourg.

Today, there's probably not a Cape Bretonner alive who isn't proud of that history.

But there's a dark side. The history of the island is also one of exporting people — out to find work, says S. M. (Stan) MacDougall, field representative here for the commission's employee assistance program (EAP).

The commission, through its EAP division, "will assist any business or industry in Nova Scotia to establish an EAP for its employees." In fact, it estimates it provides policy coverage for about one-third of the work force.

Stan MacDougall goes into places with as few as three employees and as many as 4,000. But if he sees employed people with

History

The Nova Scotia Commission on Drug Dependency is an agency of the provincial government, reporting directly to the minister of health through its board and executive director, who is also commission deputy head.

The commission came into being officially by Royal Proclamation on June 1, 1972, following reorganization of the Nova Scotia Alcoholism Research Foundation in 1971.

It stemmed from government's perception of major alcohol and other drug problems in the province, and a desire to offer services and programs which would provide effective management of these social problems.

The legislative mandate for commission operations is found in the Drug Dependency Act, Chapter 3, Statutes of Nova Scotia, 1972.

From commission documents

DIARY

At Fort Louisbourg: In the 1700s, it was the scene of fierce battles. Today, teenagers like this young Micmac, recall those days, in words and dress, for tourists.

Tour photos by H. J. Schankula

problems, he also sees too many unemployed. As much as he wants to see EAPs in every industry and office in Nova Scotia, he wants to see the employment rate up.

TUESDAY

9:30 am
Baddeck Hospital, Baddeck

We have driven for an hour or so, on a grey, misty morning, to meet Emily McKenzie, community health worker. She's waiting in her car outside Baddeck Hospital. We'll talk — Mrs MacKenzie, Mr Burke, Henry J. Schankula, director of the Education Resources Division at the Addiction Research Foundation in Ontario, and I, editor of **The Journal** — as soon as we can find an available space in the hospital.

Although the hospital board here is talking of establishing a small unit to work with the commission, Mrs MacKenzie, "satellite outpatient unit," operates essentially from her home, her telephone, and her car.

Says a commission document: "Outpatient satellite centres away from the central office of the regional service are able to offer service to people who live in communities a distance from the central service of the regional program. In effect, one may come from a distance for primary care service and may then go back to his or her home and receive help, along with his or her family, in their own community."

The soft-spoken Mrs MacKenzie is pleased to see Mr Burke, but she's also pushed; she's got a large area to cover and a lot of people to see. (Asked by Mr Burke what she'd like from head office, if they could give her anything she needs, she smiles: "Triple my mileage allowance.")

One has the feeling Mrs MacKenzie will never believe she's finished her work.

"I think we're only seeing a very small percentage of the people with alcohol problems. People die. People are sick — my heart goes out to them. I'd hate to think what would happen if all the people in this area who, in my opinion, need help, came. I don't think we could provide help for them."

But she also reckons it's unlikely they'll all come.

On drugs: "What can we do about the drug situation? It annoys me so much." At a recent meeting of parents concerned about drug use by young people, Mrs MacKenzie stood up and asked: "How many of you parents could do without alcohol?

"They don't look at themselves. That's what I find. Especially in rural areas. What are the parents doing? Discussion begins at home."

As we leave the hospital for Monastery, Mrs MacKenzie turns in the other direction for Sydney. She'll have time to herself in the car, but when she gets home, there'll be phone calls waiting. And, as likely as not, after she finally gets to bed, the phone will ring again.

Why is she going the 50 miles to Sydney? Because a woman needs help and there are no female counsellors available today. Aren't there male counsellors?

"Sometimes I visit women because some men don't want their wives to be seen by men."

12 noon
Recovery House, Monastery

As we walk down a corridor past a chapel to the director's office, the monks file by to prayers.

The schedule said Monastery. And it is — the historic St Augustine's Monastery set in the middle of country-green pastures. In a separate wing is Recovery House Addiction Treatment Centre, a residential rehabilitation program with 18 beds for males and two for females.

It provides, says a brochure, "an excellent locale for the person who has not responded to treatment from other agencies or whose home situation or general environment makes recovery difficult."

The four-week program includes physical fitness, work therapy, group reading and discussion, individual counselling, and AA meetings (only in the company of a local member).

Yvonne MacDonnell is the bilingual acting director — a nurse who joined Recovery House recently with extensive experience as a psychiatric nurse, and a nurse-educator and administrator. (Before the month is out, she'll be director — the first female executive director of Recovery House or any similar free-standing program in the province.)

"The men have really outdone themselves today," she says, as she and Wendy Panagopoulos lead the tour through the rambling old corridors.

The commission's annual grant of $84,000 helps considerably. But Recovery House also relies fairly heavily on a community that continues to show approval.

At lunch is Judge Donald J. Tramble, provincial family court judge and chairman of the Recovery House board.

Judge Tramble, who operates the metal crutches on which he must depend in the manner of a fast kid on a dirt bike, and perhaps with some of the same spirit, is optimistic about support.

He knows his community always comes through. With him around, his pipe fairly clinging to his mouth as he talks, it's unlikely the community can resist.

"It'll survive," he says of Recovery House. "It's like a cat. It always lands on its feet."

1:30 pm
St Andrew St, Antigonish

Nelda Armour, clinical therapist, is with a patient. But secretary Delia MacChesney and community health worker Walter MacMillan welcome us to this satellite outpatient centre of the North Shore Drug Dependency Centre. There's only space and time for a quick visit, but the point is really for Marvin to say hello — he tries to get across the province two or three times a year — and to arrange a lunch sometime soon with the team.

When Mrs Armour joins the small party briefly, lunch is arranged. First priority? To accommodate the dining schedule of Nelda's new baby boy.

3 pm
Pictou

Robert MacDonald, manager of treatment services for the North Shore Region in Pictou, wears his professional hat just about 24 hours a day. "You know just about everybody around," he says. And if you don't know them, they know you. Or your family. Or your neighbors.

It's the same for many of the staff here and in other centres, he says.

He is regularly updated on clients' progress, or lack of it, while he's mowing his lawn at home. Or when he's in a shopping centre, a restaurant, a cinema. Some places he and other staff avoid. Bars, for example.

"You don't go into the bars. It's embarrassing for clients and embarrassing for us." That's especially true if the client is trying to explain, while clinging to a bar stool, that he's been sober for three months now. It happens, says Rob MacDonald.

With Rod MacEachern, counsellor attendant, Mr MacDonald describes the centre's operation and community outreach.

Serving the counties of Cumberland, Colchester, Pictou, Antigonish, and Guysborough — about 155,000 people — the program includes a 17-bed detox and treatment orientation program, as well as outpatient services here in Pictou; satellite outpatient units at Truro, Antigonish, Amherst, and New Glasgow; and the facilities of Recovery House (above).

The impact the centre has on the community is reflected in a commission report excerpt.

"Resident directors and assistants at St Francis Xavier University received training sessions, along with hospital nursing staff, penitentiary staff (Dorchester and Springhill), Camp Debert Military, and Pictou County Guidance Counsellors as a group.

"The above, added to the request to set up a Student Support Program from the Pictou Amalgamated School Board, seems to point to the fact that we are perceived as a solidly established agency which is viewed as a vital community resource.

"This indicates a certain maturity of perception on behalf of the community at large and augers well for the future."

Clients

The major problems in treatment and rehabilitation centres in Nova Scotia are associated with alcohol. This is followed by poly-drug abuse and by misuse of benzodiazepines and other psychotropics. Opiates are used by a very small group of people (known cases, 150). Marijuana is prevalent — most convictions under the Narcotic Control Act are for simple possession of cannabis (85%). Tobacco also represents a large percentage of the user population that does not present in treatment centres. In 1982-83, all treatment centres served approximately 6,000 people.

The commission estimates that more than 500,000 Nova Scotians 15 years of age and older drink alcohol. Of this group, it estimates approximately 50,000 people have alcohol-related problems. Of the 50,000, approximately 16,000 have advanced disabilities, to the extent that they can be identified as being alcoholic or suffering from an alcohol dependence syndrome.

From commission documents

MacDonnell, Panagopoulos: support

WEDNESDAY

9:45 am
Valley Health Services Association
Kentville

Gaston d'Entremont is coordinator for this region, which serves a catchment area of some 80,000 people and has a five-bed detox unit and 10 beds for after-care (a 28-day inpatient program for men and women).

Alcoholism is treated as a family disease, and medical care, counselling, and education programs are offered to the patient, the patient's family, and/or significant others. There are two community health workers — one in Middleton at Soldier's Memorial Hospital, and one at Windsor, in Hants Community Hospital.

Though the inpatient program is 28 days, it isn't the 28 days, "it's the damn follow-up that counts," says Mr d'Entremont.

Here, along with community health workers, some 300 volunteers — clergy, AA members, ex-patients — help weave the net that supports patients after "graduation."

The net extends to other community agencies and institutions. This morning, a psychiatrist from the regional psychiatric hospital, phoned Mr d'Entremont to say an old man had been brought in to hospital hallucinating. When assessment showed it was alcohol withdrawal, a phone call to Mr d'Entremont got the man immediately admitted to detox.

Says a letter to patients: "While you are here, either in detox or at Crosbie House (for residential rehabilitation), you will be asked to choose a contact person — someone who can be a friend during your recovery, someone you can talk openly and honestly with. This should not be an immediate relative . . . but someone who accepts alcoholism as an illness . . . and has a willingness to try to understand it more.

"Following your choosing of a contact person, our coordinator of follow-up will meet with that person to help him understand his role as a friend in recovery. They will be asked to complete a monthly Health Questionnaire indicating the status of your sobriety and if they have kept in touch with you."

Pervading the conversation here, as elsewhere, is the sense that "the community takes care of its own."

And if it's "the damn follow-up" that counts, it's the volunteers who help make it possible.

Joubelakas, Cassidy, Noah, Meunier: the western region continues to bear character lines of early settlers

The Journal

DIARY

(from page NS-3)

1 pm
On the Evangeline Trail bound for Yarmouth

The first white settlers along this, the French shore, came from France in the early 1600s. One hundred and fifty-five years later, they were expelled from the colony by the British; it left them stranded and separated from each other across North America.

Later, many of these "Acadians" returned to this area (335 families are said to have walked here from Boston in the summer of 1768). Today, their descendants live on. They retain their mother tongue and many old customs; and now they have their own flag.

To honor the Acadians and mark their expulsion for history, Longfellow wrote a poem. His tragic heroine was Evangeline, after whom this trail is named.

4 pm
Yarmouth Regional Hospital

The history and beauty of the French shore have kept us late for Yarmouth, a town of about 9,800 people, which continues to bear the character lines of both French and English early settlers. Here, based at Yarmouth Regional Hospital, is the Western Regional Drug Dependency Program, serving the residents of four counties — Yarmouth, Digby, Shelburne, and Queens. The program includes central outpatient services and a six-bed detox and treatment program (Yarmouth Alcoholism Rehabilitation Program) at the hospital, as well as satellite outpatient service units in Liverpool, Digby, Church Point, and Shelburne.

David Cassidy, regional coordinator, knows the route we've taken to get here and has been in touch with his colleagues up the line. So he and his team aren't surprised we're late — Sandra Noah, vice-chair of the regional advisory board and head nurse on the detox unit, nurse Kathy Joubelakas, and Dan Meunier, field representative.

Sandra and Kathy are both registered nurses, graduates of the hospital that now houses the unit. On the detox unit, Sandra is boss or, frequently, "the warden." The term is applied by staff and clients alike.

That the detox unit runs smoothly is partly attributed by both Sandra and the rest of the team to her low tolerance for disruptive behavior.

"The first question people from the United States ask is: how many DTs (delirium tremens) do you see? We don't," she says, "They aren't allowed."

Neither is death. When new patients complain they just want to die, Mrs Noah sets them straight — "Sorry, we don't allow it." It appears to work.

Dan, usually out in the community working on prevention and education programs, is in the unit this week "getting the view from the other side." But, his current major involvement is peer education with between 6,000 and 7,000 kids at elementary and high school levels in the four counties.

The aim is to "start getting the young ones educated about alcohol and drugs and get the older ones to teach them." It's part of a thrust begun more than three years ago by the commission to develop peer education programs across the province.

The basic concept of the program, says a paper from the youth and school services section of the prevention and community education division of the commission in Halifax, is that "young people will listen to other young people when they have something to say." And what they share with each other should: be based on truth, be something of value, and recognize that an individual's own personal decision is essential.

THURSDAY

9:30 am
Shelburne Boys School

Fred MacDonald is the Shelburne satellite office/community health worker of the Western region program. His base is Roseway Hospital here in Shelburne, but he's often on the road. Today, he's waiting at the boys' school, garbed in his usual work clothes — jeans, a T-shirt, and boots. Clamped between his teeth is an ever-present accessory — his signature, say his colleagues — a toothpick.

It's unlikely the experiences of any of his clients, whatever age, and including the young boys here, hold any surprises for Mr MacDonald. It's the constructive use of his own past that helps him now in his role as comforter, supporter, and counsellor — perhaps especially to the kids in the population at this school who layer in to their other troubles abuse of alcohol and, sometimes, other drugs.

In Fred's discussions with Heikki Muinonen, superintendent of the school, and Terry L. Smith, assistant superintendent, there's a familiarity and ease — in all of them, and with each other — that goes beyond standard operating procedures.

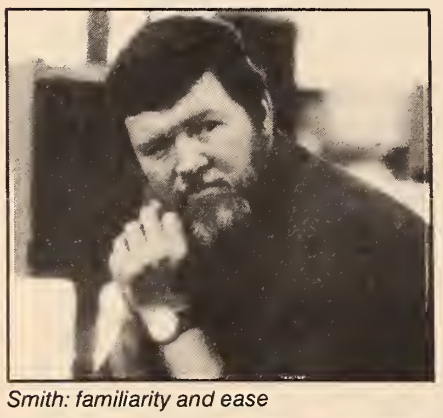
Says a commission report: "With this (Shelburne) office operational (in 1982), the original mandate of providing follow-up services in each of the four counties of the Western region was finally met.

"A great deal of appreciation and thanks must be extended to the many people of Shelburne County who indicated their support and recognition of the need for this service. The addition of this office will mean that the outpatient team from Yarmouth will be able to work more closely with the Alcoholism Rehabilitation Program at Yarmouth Regional Hospital. It also provides regular counselling and assessment services to the Nova Scotia School for Boys in Shelburne," operated by the ministry of social services. Enter Fred MacDonald.

Services in the region, says another paper, have also continued to be complemented by a growing number of self-help groups. In addition to AA and Al-Anon, 1982 marked the beginning of Narcotics Anonymous groups and an Overeaters Anonymous in Liverpool.

12 noon
Queens County Referral Centre
Liverpool

There's a Chinese restaurant — often named Wong's — in every town, village, and city in Nova Scotia. Or so it seems.



Smith: familiarity and ease

Fred MacDonald: experiences of clients hold few surprises

Muinonen: support

Howard, Harrington: aid and comfort

When we return from lunch at one of them with community health worker Carolyn Howard and Dawn Harrington, secretary to the unit, the out-to-lunch sign left on the door of the small office has had at least one reader — a teenager now waiting patiently for Carolyn and Dawn to return.

On a pie chart in one commission document, the section on alcohol takes up 86.5% of the space; it doesn't chart out how much of that is girlfriend, boyfriend, or family trouble because of alcohol. (Tranquillizers occupy 6.5% and other drugs, 6.8%.)

The three women here — Carolyn, Dawn, and the young woman waiting — all know each other and could probably add some detail. She's been before and will come again. They also all know—vaguely at least — each other's families and some of each other's friends and problems. As we leave, the three enter the centre where Carolyn will aid and comfort the first client of the afternoon.

Earlier, at lunch, was Frank Babin, a father, teacher, school principal, and member of the local committee in Liverpool.

A major problem for young people in small communities, he says, is there is so little for them to do out of school, if they're still students, and all the time, if they're unemployed, as so many are.

Involved in his community and in peer education programs, he also rates sports and sports clubs very high as preventive tools. Sports give young people something to do, something to be proud of, a place to go.

The conversation sheds new light on the kids we've seen around towns in Nova Scotia wearing their baseball uniforms, and the playgrounds we've passed with games in progress. Players are boys and girls, men and women.

FRIDAY

9 am
Halifax

Yesterday's work ended late last night for Mr Burke. Today, he began again about 7:30. But our de-briefing starts about 9 in central office at 5675 Spring Garden Road. (Several scheduled and hoped-for stops on the agenda, including one at the Dartmouth office of the Metro/Lunenburg region, have had to be cancelled because of time constraints. But Bob Sharrow, manager of treatment services for the Metro region, and just back from a Prince Edward Island honeymoon with central office staffer and schools services representative Gerri Penny, has come over to greet us).

Here are the policy directors, the research section, program advisers, and administrative supporters of the commission's work. It's the results of some of their efforts, reaching down into the communities, that we've seen this week.

On visitor duty in addition to Bob Sharrow and Gerri Penny, are: Ed Fitzpatrick, past president of the Canadian Addictions Foundation and one of the better-known workers in this field in Canada. He is EAP coordinator for Nova Scotia. The division designs programs which are, in turn, delivered by field representatives at the regional level.

Fitzpatrick

One achievement of the division: the Maritime Telegraph and Telephone Company Limited estimates it saves more than $200,000 each year because of its EAPs.

Carol Amaratunga, coordinator, prevention and community education division: The division's role is to provide services to the community, increase public awareness of hazardous drug use, and to present an opportunity to change attitudes and values. The approach is three-tiered: it develops awareness through mass media and advertising, as well as programs attracting large audiences; provides opportunities for people to meet in smaller groups and develop new attitudes; and provides opportunities for people to develop skills to follow through on their new knowledge and attitudes. The division, through its staff, works closely with local committees.

Amaratunga

Brigitte Neumann, coordinator, documentation, evaluation, and research: A major program is the Service Delivery Information System (SIDS) designed to meet information needs for program review and performance measurement. The system (computerized) produces a range of reports of service utilization for each program within each region, for any specified time period. It can also produce a range of demographic, social, and drug dependency characteristics of clients and report on the extent to which clients are linked to ongoing treatment, not only within commission programs but also to other community agencies and groups.

Neumann

The coordinator conducts research with faculties of medicine, health sciences, and sociology at Dalhousie and St Mary's universities.

Not on visitor duty is Brian Wilbur, coordinator of school services: Prominent in this area was the implementation in 1982 and subsequent development of the Community Outreach Program, piloted in Halifax West and now expanded to Cole Harbour. This program attempts to educate the community regarding drug issues and directs its attention in a three-phase program specifically to parents, students, and teachers, through peer education, parent education, and early referral. Indications are the program is working and that each phase can be transported to other school community settings.

Budget

The commission's current annual budget is about $5.8 million; approximately 25% is allocated to central office and the remaining 75% goes to regional programs.

Of the overall total, about 58% goes to treatment and rehabilitation programs. Nine per cent goes to prevention and education; 3% to documentation, evaluation, and research; 2% to industrial and business programs; 3% to policy and supervision services; 4% to operational administration, accounting, and personnel; and 21% to supplies and services.

Overall, specific program delivery takes up about 72% of the budget, with the remaining 28% to administration.

About 37% of the budget is recovered from the federal government under the Vocational Rehabilitation of Disabled Persons Act for services assisting people returning to work after treatment and rehabilitation.

From commission documents

FEATURE

Control of availability approach 'bankrupt with failure'

US beverage industry answers its critics

By Harvey McConnell

WASHINGTON — The alcohol beverage industry in the United States is tired of being attacked *ad lib* by an increasingly strident neo-prohibitionist lobby.

This was made plain by speakers from the distillers, vintners, and brewers at a session here of the annual conference of the Alcohol and Drug Problems Association of North America (ADPA) who, in turn, attacked some of the antics of the anti-liquor lobby.

Robert Kirk, director, social research and education, Distilled Spirits Council of the US, Inc, noted "some people seem to have forgotten" that the 21st amendment (repealing prohibition) "gives to the states and to their citizens the right to decide laws and regulations for the sale of alcohol."

Warning labels would do nothing more than stigmatize any and all forms of drinking and would prevent nothing.

Kirk

He cited industry beliefs in employee assistance programs (EAPs) and the facts that alcoholism is an identifiable, treatable illness, and that alcoholics can be helped. As well, he said, research should be judged on its merit without being disparaged or dismissed out of hand because of what group or agency funded the research.

"We believe America is a pluralistic society with diverse attitudes, preferences, and drinking practices. We believe also in the right of commercial speech for advertising messages," Mr Kirk continued.

While there is no law prohibiting advertising spirits on television or radio in the US, the industry voluntarily has chosen not to do so.

Mr Kirk continued: "We agree with major research in analytical studies, as well as practical experience. And I think there is a lot of research experience we could all benefit from which shows that the control of availability approach to prevention is bankrupt with failure in every country in which it has been tried.

"And if you don't believe me, take a look at the Soviet Union and a lot of the Eastern bloc countries. We aren't Scandinavia. We aren't Russia. This is the United States."

Warning labels would do nothing more than stigmatize any and all forms of drinking and would prevent nothing, Mr Kirk said. His organization believes in "education about alcohol and not education for or against alcohol."

In the wine industry, a strong US dollar, and a "wine lake" in Europe, means millions of gallons of French and Italian wine are being dumped on the US market.

Patricia Schneider, education director for The Wine Institute in California said France and Italy heavily subsidize their wine industries and put up trade barriers to California wine. But, in the US, the dumping is so serious, and the wine is being pushed "in ways we don't think appropriate," that the institute has asked the US government to adopt the institute's code of conduct on advertising as a national regulation.

Ms Schneider noted that the institute's code of conduct forbids the use of amateur and professional athletes in advertising. Advertising is not permitted in youth-oriented magazines, nor can appeals be made to specific racial groups.

Ms Schneider said the wine industry is concerned about attempts to ban advertising of alcoholic beverages on radio and television. "This attempt, which does not represent a mainstream philosophy, nor does it have the backing of the main alcoholism groups, nonetheless has captured some media attention and is an attempt to go after a product as a way of defining alcohol issues and alcohol problems."

She pointed out that the institute has worked with the US department of transport on the drunk-driving issue, as well as with Mothers Against Drunk Driving (MADD) and Students Against Driving Drunk (SADD).

A national minimum drinking age of 21 years will remain controversial and it may create "a whole group who drink anyway and we brand them as illegal." But the wine industry believes that if a uniform 21-year-old drinking age among the states would help reduce drinking and driving tragedies, especially among that age group, the industry should support it.

Ms Schneider said it is hoped the wine industry will benefit as more and more people adopt a moderate style of living. The industry wants to promote the proper use of wine, "and we feel prevention does not have to be prohibition, and that the industry's legitimate right to exist and to present its products in a responsible manner can do more to promoting public health than all the prohibition slogans."

The Canadian and US brewing industries are the main contributors to the Alcohol Beverage Medical Research Foundation set up at Johns Hopkins University in Baltimore, which recently sponsored a major conference on alcohol and highway safety (**The Journal**, Aug, July).

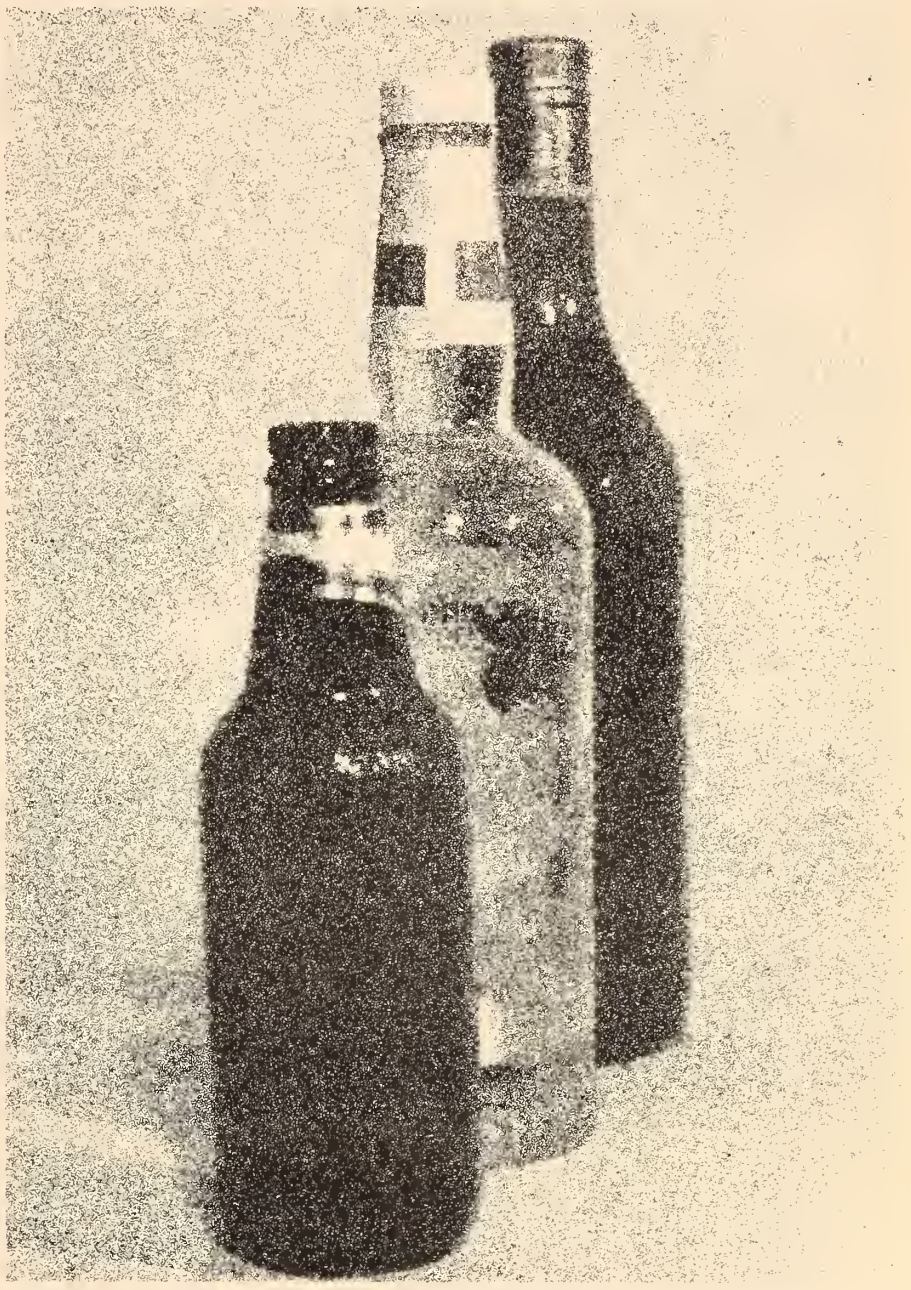
Terry Callahan, director of alcohol programs of the US Brewers Association, said that at that conference "all points of view were aired including some that were rather critical of the alcohol beverage industry, but no one was denied a hearing."

As for the current controversies, "the old sin-industry image has been the rule not the exception over the last 100-odd years of American history" but today, "this ever-popular morality play is currently enjoying a revival" in the US.

The industry's right to exist and present products in a responsible manner can do more toward promoting health than all the prohibition slogans.

Schneider

Ms Callahan said the irony is that the new control movement "has peaked at a time when the alcohol beverage industry is doing more to prevent the misuse of our products than ever before. I am not saying we shouldn't be doing more, but the current atmosphere is making cooperation very difficult."



No one from the brewing industry has ever denied beer can be misused, but "our most vocal critics have not been as forthright in recognizing that the vast majority of people do use alcohol safely and in moderation. In their zeal to regulate, they have confused use with misuse."

The control of consumption theory — or prohibition — is again in vogue. Ms Callahan pointed out that for 13 years the US was supposedly dry but crime and drinking flourished.

"If an outright ban on the sale of alcoholic beverages failed to eliminate misuse, I have difficulty believing the various control measures proposed today — such as bans on alcohol and beverage advertising or warning labels — will make much difference," Ms Callahan told the conference.

The brewing industry has concentrated its prevention efforts in three areas: education among high school and college students; EAPs; and research into the causes of alcoholism and alcohol misuse.

However, "one of the most frustrating aspects of the current swing back to prohibitionist measures is that education has been getting pushed aside. Lately, I've heard a lot of people saying that alcohol education does not work and, therefore, control measures are the only way to go," she said.

The truth is that "we haven't given education a chance to work. It is only recently that many school systems have even begun to adopt any type of alcohol awareness program. There are still many who believe that ignorance is the best kind of education."

Much of the education effort has been aimed at young people, and not enough time has passed to say if education has worked or not, Ms Callahan said. And, it is possible to persuade people to change their personal habits: the major emphasis on personal fitness in the US was not brought about by passing a law saying "thou shalt jog."

The brewing industry, since 1982, has helped the SADD expand nationwide education programs for high school students, yet in some quarters the industry has been charged with a thinly disguised attempt to encourage high school students to drink. This is because of the SADD's "contract for life," in which students and parents promise to call each other should either become involved in a potential drunk-driving situation.

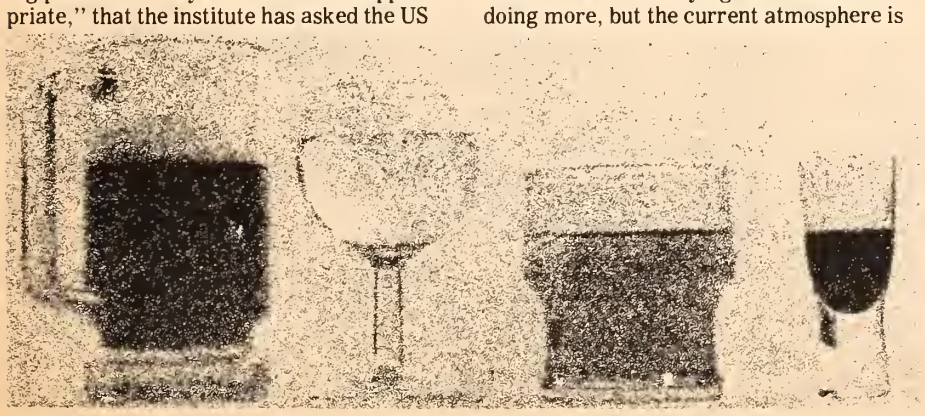
Ms Callahan pointed out government statistics consistently show that close to 90% of high school seniors have consumed alcoholic beverages in the preceding year, and drunk driving continues to be a leading cause of death among teenagers.

Ms Callahan concluded that while it is natural for the alcohol field to view the alcohol beverage industry with suspicion, "viewing us as the evil empire is unfair and unlikely to lead to constructive answers to the problem of alcohol misuse.

"I believe there is a middle ground, and it is in the public's best interest that we find some means to cooperate."

Many schools have just begun to look at alcohol awareness. Many believe ignorance is the best kind of education.

Callahan



NEWS

Cayman Islands will aid drug agents

Diplomatic move opens bank files

By Thomas Land

LONDON — A delicate diplomatic accord signed here by Britain and the United States has breached the tough banking secrecy laws of the Cayman Islands. The Caymans have sheltered vast financial fortunes amassed by criminal syndicates who exploit the North American drug trade.

Similar agreements may well follow shortly to expose the financial dealings of drug runners using banks elsewhere in the Caribbean.

The present accord follows many months of negotiations; they were triggered last year when a United States grand jury investigating cocaine smuggling into southern Florida coerced a Canadian bank into revealing secrets about its accounts in the Cayman Islands — contrary to the laws of that British dependency.

The banking secrets of the international drug syndicates emerged as a hotly-pursued international issue at the beginning of this decade when the United Nations (UN) became aware of the magnitude of the funds involved (**The Journal**, Jan).

The governments of the British Commonwealth have since established a joint fraud investigation department concerned with a range of "white-collar" crime including drug smuggling. It has so far rendered assistance in cases involving the loss of more than $12 billion.

The bank secrecy laws of the Caymans are even tougher than those of Switzerland. Despite their legendary "discretion," Swiss bankers are obliged to expose secret bank accounts to scrutiny if their holders are under investigation for serious crime. But in the Caymans, a bank official risks imprisonment for so much as confirming the existence of a suspected account.

The Anglo-American accord will end this without necessarily endangering the reputation of the Caymans as a dependable tax haven. The agreement will provide narcotics investigators unhindered access to suspected accounts if they can convince the attorney-general of the islands that the inquiries are related only to drug offences. The arrangement will be reviewed in nine months and may then be widened into a law enforcement treaty concerned with a range of offences such as fraud.

Cayman Islands: secrecy laws are tougher than Switzerland's

Britain's Foreign Office comments that similar measures may well follow elsewhere to ensure that the country's remaining overseas dependencies are not used by drug traffickers for illegal financial operations. Such measures have been sought by the Commonwealth for some years. Its collective fraud investigation office — a department of the Commonwealth Secretariat here in London — declared shortly after its establishment in 1982:

"Many small countries, whose national budgets would be pocket money to the international criminals, unwittingly play host to them by allowing them to deposit money in their banks.

"Such countries easily become operational centres for the criminals, and ultimately their governments and national economies are taken hostage by a nameless force whose money is backed by drugs, guns, and an ever-widening circle of corruption and manipulation . . . ."

The UN's International Narcotics Control Board earlier warned governments that "illicit (drug) production and trading have grown to vast proportions, and the attendant financial transactions have generated sums of such staggering size that the economic and political stability of some countries is now threatened."

Another factor contributing to the Caymans accord has been intense pressure generated by the banking community. It sought to change the conditions leading to the embarrassment suffered last November by the Bank of Nova Scotia, whose subsidiary in the US was fined $25,000 a day until it produced secret financial documents related to a bank account held in the Caymans.

The Canadian bank asked the Caymans government for permission to release the documents wanted by the US grand jury. The Caymans responded by issuing an injunction preventing disclosure — but eventually it relented under the weight of international legal and diplomatic pressure. The controversy may thus have opened the door to the investigation of suspect banking secrets in many countries.

Health coalition deplores cig ads

TORONTO — A coalition of health agencies is trying to force tobacco advertisements out of Canadian newspapers.

The coalition includes the Toronto-based Non-Smokers' Rights Association (NSRA), the Canadian Cancer Society, and the Canadian Council on Smoking and Health (CCSH). They are seeking public support to pressure newspaper publishers voluntarily to withdraw tobacco ads.

A complaint earlier this year to the Canadian Advertising Standards Council (ASC) and newspaper publishers failed to bring the hoped-for response. In fact, said Garfield Mahood, executive director of the NSRA, more than half the major newspapers did not even carry a news item on the complaint. To get coverage, the NSRA placed a full-page ad in *The Globe and Mail* detailing the dispute, he told a press conference.

The complaint, filed with the ASC in May, claims tobacco ads violate the ASC's own code, which prohibits ads depicting "situations which might encourage inappropriate, unsafe, or dangerous practices."

David Nostbakken, PhD, of the CCSH, pointed out that 30,000 Canadians die each year from tobacco-related disease. "It no longer makes sense to continue to promote a product through advertising which promotes that kind of consequence."

DEPARTMENTS

New Books

by RON HALL

Establishing and Building Employee Assistance Programs

. . . by Donald W. Myers

Troubled employees can cause major disruptions in the smooth functioning of an organization's workforce. Through their conduct and related behaviors such as absences, tardiness, accidents, theft, and sabotage, these employees cause most of the problems related to work quality and output. This book examines the issue of the troubled employee and the costs, trends, and managerial strategies for prevention and rehabilitation. Traditional employee assistance programs (EAPs) are analyzed and the elements of successful programs are detailed. The book is intended for executives, line managers, personnel managers, and counsellors establishing or administering EAPs.

(Quorum Books, 88 Post Rd W, Box 5007, Westport, CT 06881, 1984. 335 p. $39.95. ISBN 0-89930-044-8)

The Drug User: Personality Issues, Factors, and Theories

. . . by Stanley Einstein

This bibliography contains 2,262 citations of articles dealing with aspects of the personality of the drug user. An extensive introduction provides information on classification systems; drug user personality theories and intervention; factors initiating treatment; the screening process; and treatment goals. It is hoped that the issues raised will be helpful as the reader peruses the growing drug personality literature. The unannotated bibliography section is arranged alphabetically by senior author and is composed of three sections: articles; articles in books, books, dissertations; and presentations.

(Plenum Press, 233 Spring St, New York, NY 10013. 1983. 208 p. ISBN 0-306-40913-5)

Other books

Back in Control: How to Get Your Children to Behave — Bodenhamer, Gregory. 1983. Mandatory, optional, and discretionary rules; unclear directions; ineffective follow-through; inconsistency; index. 114p. Prentice-Hall, Englewood Cliffs, NJ 07632. $5.95. ISBN 0-13-056870-8.

The Non-Profit Organization: An Operating Manual — Wolf, Thomas. 1984. General overview of nonprofit organizations; the brand; the staff; planning; financial management; keeping financial records; information management; fund raising; index. 184p. Prentice-Hall, Englewood Cliffs, NJ 07632. $8.95. ISBN 0-13-623315-5.

Dictionary of American Temperance Biography — Lender, Mark Edward. 1984. Brief biographies of 373 individuals active in the cause of temperance and efforts against alcoholism from the 1670s to the 1980s; index. 572p. Greenwood Publishing, 88 Post Rd W, Box 5007, Westport, CT 06881. $45. ISBN 0-313-22335-1.

The Three Robots — Fettig, Art. 1981. Story about three robots, one with a positive attitude, one who never seems to get around to being successful and happy, and one who is a negative thinker. 95p. Growth Unlimited, 31 E Ave S, Battle Creek, MI 49017. $3.95. ISBN 0-9601334-4-5.

The Three Robots and the Sand Storm — Fettig, Art. 1983. The second in the series; three robot friends are trapped in a sand storm; the story discusses the meaning of friendship. 90 p. Growth Unlimited, 31 E Ave S, Battle Creek, MI 49017, $3.95. ISBN 0-961334-4-7.

The Three Robots Find a Grandpa — Fettig, Art. 1984. The third in a series; the book is the story of the robots meeting an unhappy old man; the robots teach him how to become loveable; the series is intended for children and to prevent many of the addictions encountered in later years. 95p. Growth Unlimited, 31 E Ave S, Battle Creek, MI 49017. $3.95. ISBN 0-96013348-8.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000 ext 7384.

Drugs: Drinking, Driving

Number: 625.
Subject heading: Impaired driving
Details: 18 min, color.
Synopsis: The most popular drug used by adults is alcohol which, when combined with driving, can be a great problem. However, many prescription drugs can cause the same effects as alcohol and may be just as dangerous for driving. Two people drive a test route for 25 consecutive hours; one then takes a depressant, while the other takes a stimulant. Neither subject can continue driving adequately although, as expected, the driver with the stimulant continues driving for longer than the one who has been given the depressant.
General evaluation: Poor to very poor (1.8). This film is no longer up-to-date, and the experiment was so questionable as to preclude any useful learning.
Recommended use: Archives.

The Odds Are Against You

Number: 626.
Subject heading: Impaired driving.
Details: 6 min, color, 16 mm.
Synopsis: A series of vignettes about drinking and driving: if you drink and drive the odds are against you, you are playing a numbers game. In one scene, a young woman tells of breaking up with her boyfriend because he drove after drinking. Another scene shows young people insisting on driving a drinking friend home.
General evaluation: Fair (3.4). This contemporary film could be a good discussion starter.

Recommended use: With a resource person, could be used with young people aged 15 to 18 years.

One For My Baby

Number: 627.
Subject heading: fetal alcohol syndrome (FAS).
Details: 28 min, color.
Synopsis: To date, researchers have been unable to establish a safe level of alcohol consumption for pregnant women. Even women contemplating pregnancy are warned against the hazards of drinking. Harmful effects on the fetus vary with the amount of alcohol consumed. "Heavy drinking" can result in a set of symptoms called fetal alcohol syndrome (FAS). Damage is life-long and cannot be corrected. Two sets of parents discuss their feeling about having children with FAS, and warn even potential fathers not to drink.
General evaluation: Good to very good (4.8). This contemporary, well-produced film had a clear message about the possible effects of alcohol on an unborn child. General broadcast was recommended.
Recommended use: With a resource person, this film would benefit prospective parents.

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PAIN MANAGEMENT EXCERPTS

(Continued from The Back Page)

ml water) to morphine sulphate, has been described by workers at the United States National Cancer Institute, Bethesda, MD. Freeze-dried morphine acetate has been prepared as a solution containing 100 mg morphine per ml. Considerable work would be needed to prepare such a formulation for marketing.

Apart from its solubility, does subcutaneous or intramuscular heroin have any advantages over subcutaneous or intramuscular morphine? Clinical studies of the two narcotics given by injection have been carried out at Georgetown University School of Medicine, Washington, and at Memorial Sloan-Kettering Institute for Cancer Research, New York. Heroin was found to have a slightly more rapid onset and a slightly shorter duration of action than morphine. This confirms earlier observations. In neither trial, however, did heroin differ significantly from equianalgesic doses of morphine in its ability to relieve pain, alter mood, or cause side effects. It should also be noted that when morphine is given regularly to continuously prevent pain, the small differences in rapidity of onset and duration of observed actions are of no clinical importance.

The information gathered by the Committee during visits to two of Canada's best known palliative care units is pertinent. In these units, with the use of modern techniques and available drugs, pain care is such that none of those who spoke to the Committee could identify situations in which uncontrolled pain indicated to them that the availability of heroin would have been useful.

Dr Robert Twycross, a recognized expert in the treatment of cancer pain and in the use of heroin and morphine in the United Kingdom, told the Committee:

"To claim that heroin is necessary to relieve cancer pain ignores the equal success of North American and British hospices in pain management. It also ignores the close relationship (chemical and pharmacological) between heroin and morphine and stems from a desperate but futile search for the panacea for cancer pain.

"There is not one shred of evidence that heroin is necessary to obtain pain relief in cancer."

Recently, Dr T. Walsh and Dame Cicely M. Saunders stated the issues eloquently. These internationally recognized experts conclude:

"The heroin controversy distracts attention from substantive issues in the care of patients with advanced cancer namely, the need to improve the general standard of care and symptom control and to ensure that adequate doses of analgesics are correctly employed from among the many opiate and non-opiate drugs that are already available."

The only countries which have a consumption of over 1 kg are the United Kingdom, consuming 150 kg and Belgium, 2 kg. After discounting the amount used in the United Kingdom for the heroin maintenance program for heroin addicts, one probably has an amount which is equivalent to the treatment of all terminal cancer victims for two months. It is realized of course that all terminal cancer does not involve extreme pain and two months may not represent the average time for which the drug is used. Much of the small heroin consumption listed for other countries may well be for chemical analytical purposes.

On this basis, then, it is misleading to claim that many countries permit the use of heroin and use this as an argument for its reintroduction when in fact the only country which is using it significantly in the treatment of terminal cancer is the United Kingdom.

Conclusion

We conclude, therefore, that the deficient pain control experienced by cancer patients in Canada is not related to a need for heroin but to inadequate knowledge and prescribing practices concerning narcotic analgesics and the existence of some pain syndromes which are not responsive to narcotic analgesics for which other therapeutic options must be developed. In Britain, where heroin is available, poor pain control still occurs. Improvement in pain control will occur through the dissemination and application of current knowledge and treatment tactics and continuing research regarding the management of problem cases. If heroin were available in Canada, the fundamental causes of inadequate pain control would not change. What must change is how we use the available agents.

Recommendations

Based upon presently available scientific data and medical needs, the Committee concludes that, properly used, the analgesic drugs and other measures currently available in Canada are sufficient to relieve severe chronic pain in cancer patients with few exceptions. The latter cases would not be helped by the introduction of heroin.

• Heroin not be reintroduced in Canada at this time since the information available does not support the need for this drug.

• The development and marketing of the following be encouraged: a high-concentration form of hydromorphone suitable for low volume subcutaneous or intramuscular injections; a high solubility salt of morphine; a commercially available injectable form of methadone; higher concentration formulations of morphine hydrochloride or sulfate; sublingual and rectal formulations of currently marketed potent analgesics.

● *Research*

A full understanding of the pathophysiology of a disease process will foster appropriate and specific therapy.

More scientific information is needed concerning:

a) the extent of the problem of inadequately controlled severe chronic pain in Canada.

b) the basic and clinical neurophysiology, pharmacology, and pathophysiology of chronic severe pain.

c) the origin of interindividual variations in response to treatment as a base for optimizing treatment regimens.

d) the efficacy of antidepressants and other adjunctive drugs in treating pain.

e) development of new drugs with fewer side effects.

Recommendations

In view of the paucity of demographic data related to uncontrolled pain in Canadian cancer patients, we recommend that:

• Epidemiologic studies be performed to further define the dimensions and characteristics of the problem of severe pain as it exists in Canada. The National Health Research and Development Program could stimulate research in this area.

In consideration of a perceived need to increase our basic, clinical and pharmaceutical industry research efforts, we recommend that:

• The Medical Research Council and Natural Sciences and Engineering Research Council be asked for their assessment of our current efforts in pain research, whether further effort is needed, and what steps could be taken to encourage such research if a need is identified. In this context, consideration could be given to assigning specific funds to support basic and clinical research concerning pain.

• Initiatives be taken to encourage the pharmaceutical industry to develop and test new analgesic agents in Canada.

The Committee:

The membership of this Committee included:

E.M. Sellers, MD, PhD, FRCP (Chairman), Professor of Pharmacology and Medicine, Assistant Dean, Undergraduate Medical Curriculum, University of Toronto; Director, Clinical Institute, Addiction Research Foundation, Toronto, Ontario.

B.M. Mount, MD, FRCS (Vice-chairman), Professor of Surgery, McGill University; Director, Palliative Care, McGill University, and Royal Victoria Hospital, Montreal, Quebec.

G.W. Bethune, MD, FRCS, Professor, Department of Surgery, Dalhousie University, Halifax, Nova Scotia.

L.M. Chevalier, MD, FRCP, Assistant Professor, McGill University; Director, Oncology Clinic, Montreal Children's Hospital, Montreal, Quebec.

J.G. Edmeads, MD, FRCP, Associate Professor of Medicine, University of Toronto; Head, Division of Neurology, Sunnybrook Medical Centre, Toronto, Ontario.

R.A. Macbeth, MD, FRCS, Executive Vice-President, Canadian Cancer Society and National Cancer Institute of Canada, Toronto, Ontario.

J.W. Meakin, MD, FRCP, Executive Director, Ontario Cancer Treatment and Research Foundation, Toronto, Ontario.

P.A. Mitenko, MD, FRCP, Associate Professor of Medicine and Pharmacology, University of Manitoba; Section Head, Clinical Pharmacology, Health Sciences Centre, Winnipeg, Manitoba.

I.H. Plenderleith, MD, FRCP, Clinical Professor of Medicine, University of British Columbia; Head of Medical Oncology, Cancer Control Agency of British Columbia, Vancouver, British Columbia.

Y. Quenneville, MD, FRCP, Associate Clinical Professor, University of Montreal; Department of Psychiatry, Hôpital Notre-Dame, Montreal, Quebec.

T. DaSilva, MD, FRCS (Executive Secretary), Chief, Central Nervous System Division, Health Protection Branch, Department of National Health and Welfare, Ottawa.

I.W.D. Henderson, MD, FRCS (Participant Observer), Director Bureau of Human Prescription Drugs, Health Protection Branch, Department of National Health and Welfare, Ottawa.

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Community Development Workshop — Nov 5, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation (ARF), 8 May St, Toronto, ON M4W 2Y1.

Developing a Professional Image — Nov 16, Toronto, Ontario. Information: Ontario Association of Applied Kinesiology, PO Box 2081, Station B, Rexdale, ON M9V 2G2.

Detox Training Programs (Non-medical) — Nov 19-23, Toronto, Ontario. Information: Diane Hobbs, Coordinator of Detox and Rehabilitation Programs, ARF, 33 Russell St, Toronto, ON M5S 2S1.

Drinking and Driving — Together We Can Beat It — Nov 22-23, Winnipeg, Manitoba. Information: Project Prevention, Bldg 3, 2nd fl, 139 Tuxedo Ave, Winnipeg, MB R3N 0H6.

Drinking and Driving: Legal Issue? Social Problem? — Nov 23, Toronto, Ontario. Information: Catherine Blake, Coordinator for special events, ARF, 33 Russell St, Toronto, ON M5S 2S1.

Educating Youth — A Community Response — Nov 22-23, Hamilton, Ontario. Information: Lynda Delsey, Education Youth, Rm 109, 50 Acadia Dr, Hamilton, ON.

Perspectives on Employee Assistance Programming Course — Nov 26-29 — Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Chemical Abuse and Your Employee — Nov 28, Jan 23, 1985, Toronto, Ontario. Information: Yvonne Johns, department head, Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Group Therapy Course — Jan 14-18, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Ontario Psychiatric Association Annual Meeting — Jan 24-26, 1985, Toronto, Ontario. Information: Frank E. Cashman, Program Committee Chairman, or Jean Reed, Executive Secretary of the Ontario Psychiatric Association, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Health Promotion Workshop —Feb 13-15, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

The Manager and the Troubled Employee — Feb 20, 1985, Toronto, Ontario. Information: Yvonne Johns, department head, Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

What Every Employer Needs to Know — Feb 20-22, 1985, Toronto, Ontario. Information: Yvonne Johns, department head, Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

The Supervisor, The Union Rep and the Poly-Drug User — Feb 21, 1985, Toronto, Ontario. Information: Yvonne Johns, department head, Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Behavioral Interventions Course — March 27-29, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Strategies for Coordinating Community Services Workshop — April 22-24, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Marital and Family Therapy Course — May 8-10, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Parent Resources Institute for Drug Education (PRIDE-CANADA INC) 1st Annual National Conference — May 30-June 1, 1985, Saskatoon, Saskatchewan. Information: Ruth Kell, Convenor, PRIDE-CANADA, Ste 111, Thorvaldson Bldg, College of Pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

Alcohol, Other Drugs and the Law Course — June 5-7, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Advanced Clinical Social Work Certificate Program — June 17-28, 1985, Toronto, Ontario. Information: Allen Cutcher, School of Continuing Studies, University of Toronto, 158 St George St, Toronto, ON M5S 2V8.

Summer School for Addiction Studies — July 15-26, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-10, 1985, Calgary, Alberta. Information: Jan Skirrow, Chairman, 34th ICAA Congress, AADAC, 6th fl, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

United States

4th Annual Fall Conference on Alcoholism — Nov 7-9, Williamsburg, Virginia. Information: Craig Nuckles, director, Riverside Hospital Alcoholism Treatment Program, J. Clyde Morris Blvd, Newport News, VA.

2nd Annual BNA Conference on Alcohol and Drugs in the Workplace — Nov 8-9, Washington, DC. Information: Registrar, Alcohol and Drugs Conference, The Bureau of National Affairs, Inc, 1231 25th St, NW, Ste S-602, Washington, DC 20037.

AMERSA (Association for Medical Education and Research in Substance Abuse) 8th Annual Conference — Nov 8-9, Washington, DC. Information: Conference Coordinator, c/o David Lewis, MD, Brown University, Program in Medicine, Box G, Providence, Rhode Island 02912.

State of Ohio — Prescription Drug Abuse Conference — Nov 8-9, Toledo, Ohio. Information: Jim Carter, Conference Chairman, SASI, 2012 Madison Ave, Toledo, OH, 43624.

Intimacy, Shame and Alcoholic Family Recovery — Nov 9-10, Farmington Hills, Michigan. Information: Elaine Hughes, Fairlane Health Services Corporation, Ste 1027 Parklane W, Dearborn, MI 48126.

2nd National Conference on Alcohol and Drug Abuse Programming for Colleges and Universities — Nov 11-14, Boston, Massachusetts. Information: Eric Scharf, Alcohol and Drug Problems Association, 1101 15th St, NW, #204, Washington, DC 20005.

Alcoholism, Drug Dependence, and Family Recovery — Nov 12-16, Minneapolis, Minnesota. Information: Seminar Coordinator, Johnson Institute, 510 1st Ave N, Minneapolis, MN 55403.

Hope for the Children — Nov 14-15, Santa Barbara, California. Information: National Council on Alcoholism, 133 E Haley St, Santa Barbara, CA 93101.

Kid's Stuff III: A Conference on the Prevention of Alcohol/Chemical Abuse Among Youth — Nov 14-16, Austin, Texas. Information: Peggy Frias-Lynch, Texas Commission on Alcoholism, 1705 Guadalupe St, Austin, TX 78701.

Assessing and Treating Adolescents for Alcohol and Drug Abuse — Nov 15-17, Dallas, Texas. Information: Seminar Coordinator, Johnson Institute, 510 1st Ave N, Minneapolis, Minnesota 55403.

Chemical Dependency: Children's Issues — Nov 19, **Chemical Dependency: Children's Programming**, — Nov 20-21, Milwaukee, Wisconsin. Information: Patricia Faubert, Training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

Assessing Community Needs for Alcoholism, Drug Abuse, and Mental Health Services — Nov 27-29, Tucson, Arizona. Information: Tom Donovan, ADAAPT, 4500 E Speedway, Ste 21, Tucson, AZ 85712.

9th Southeastern Conference on Alcohol and Drug Abuse — Nov 28-Dec 2, Atlanta, Georgia. Information: Barbara Turner, Charter Medical Corporation, Addictive Disease Division, 5780 Peachtree Dunwoody Rd, NE, Ste 170, Atlanta, GA 30342.

Family Systems — Nov 29-30, San Diego, California. Information: Seminar Coordinator, Johnson Institute, 510 1st Ave N, Minneapolis, Minnesota 55403.

Cultural Aspects of Alcoholism — Dec 6-8, Beaumont, Texas. Information: Bill Rosemon, Texas Black Alcoholism Council, PO Box 8066, Houston, TX 77288.

Family Recovery from Alcoholism and Drug Dependence — Dec 10-14, Minneapolis, Minnesota. Information: Seminar Coordinator, Johnson Institute, 510 1st Ave N, Minneapolis, Minnesota 55043.

11th Annual Symposium, Alcoholism — The Search for the Sources — Jan 16-18,, 1985, Raleigh, North Carolina. Information: Alcoholism Research Authority, c/o Wing B Medical School Building 207-H, University of North Carolina, Chapel Hill, NC 27514.

1st Annual Convention on Children of Alcoholics — Feb 24-28, 1985, Orlando, Florida. Information: Conference Coordinator/Disney, The US Journal, 2119-A Hollywood Blvd, Hollywood, FL 33020.

NECAD Northeastern Conference on Alcoholism and Drug Dependence — March 24-27, 1985, Newport, Rhode Island. Information: Edgehill Newport Foundation, Beacon Hill Road, Ste 106, Newport, RI 02840.

PRIDE's International Conference on Youth and Drugs — April 24-27, 1985, Atlanta, Georgia. Information: PRIDE, 100 Edgewood Ave, Ste 1216, Atlanta, GA 30303.

Central Region Conference of the Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA) — May 7-10, 1985, St Louis, Missouri. Information: Della Kinsolving, c/o St Elizabeth Medical Center, 2100 Madison Ave, Granite City, Illinois 62040.

Abroad

Prophylactics of Drug Abuse — Dec 10-12, Warsaw, Poland. Information: Secretariat of the Symposium, Society for Prevention of Drug Abuse, Aleje Ujazdowskie 22, 00-478 Warsaw, Poland.

European Working Group on Drug Policy Oriented Research — Dec 13-14, Rotterdam, The Netherlands. Information: Wijnand Sengers, Erasmus University, PO Box 1738, 3000 Rotterdam, The Netherlands.

International Youth Forum on Alcohol and Drugs — July 9-12, 1985, Cardiff, United Kingdom. Information: Myrddin Evans, Addiction Unit, South Glamorgan Health Authority, Whitchurch Hospital, Whitchurch, Cardiff, CF4 7XB, United Kingdom.

3rd International Conference on Alcohol and Drug Abuse — Aug 11-14, 1985, Lima, Peru. Information: L. Vasquez, MD, International Education, Peruvian College of Physicians, Wadsworth, Illinois 60083.

2nd National Drug Institute ("Social Change and Drug Use Patterns") — Aug 14-16, 1985, Darwin, Northern Territory, Australia. Information: NDI Planning Committee, NT Drug and Alcohol Bureau, department of Health, GPO Box 1701, Darwin, NT 5794, Australia.

12th International Conference on Health Education — Sept 1-6, 1985, Dublin, Ireland. Information: H. D. Crawley, Director, Health Education Bureau, 34 Upper Mount St, Dublin, Ireland.

International Symposium on Alcohol Problems — Dec 15-16, 1985, Madurai, India. Information: S. Selvin Kumar, Blue Cross Society of India, Palkalai Nagar, Madurai-21, India.

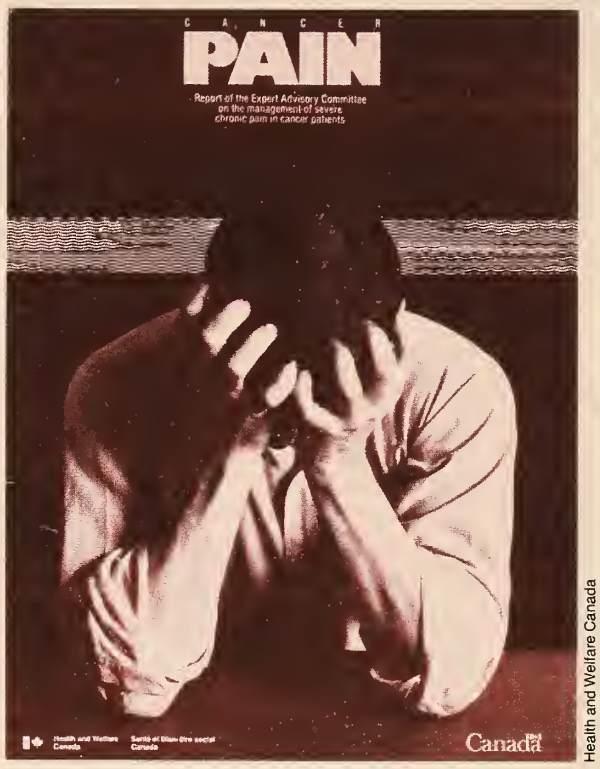
PAIN MANAGEMENT: Excerpts from an expert committee report to the federal government

A 10-member committee, set up in 1983 by the federal government to examine the problem of pain management in Canada, recently submitted its report to the Ministry of Health (The Journal, October) along with a Monograph on the Management of Cancer Pain.

Among other things, the committee — the Expert Advisory Committee on the Management of Severe Chronic Pain in Cancer Patients — concluded that available information does not support the need for the reintroduction of heroin in Canada.

The report focuses on three questions: Why is the optimal treatment of severe pain not achieved? What can be done to improve the management of severe pain? Would the availability of heroin have any impact on improving management of severe pain?

The Journal ***presents excerpts from that report. The Summary and Recommendations are reprinted in their entirety.***



Health and Welfare Canada

Summary

During the past several years, considerable controversy has developed in Canada concerning the management of pain in cancer patients and specifically with respect to the role that heroin, a drug not available in Canada, could play to improve the management of such patients. At the same time, there has been concern that drugs presently available for the treatment of severe pain are not always used to their best advantage. No clinical epidemiological study has been done in Canada to determine the incidence of inadequate management of chronic severe pain in cancer patients. Nor has there been a systematic determination of the etiology of less-than-optimal treatment. Oral morphine carefully and regularly administered to prevent pain is effective in 90% of patients with cancer pain. Adjunctive measures and morphine by injection in appropriate doses is effective in virtually all other patients.

However, clinical experience and the scientific medical literature are remarkably consistent in their judgement that treatment failure occurs and that most such failures are preventable. While there are gaps in our knowledge of the pathophysiology of pain and deficiencies in our armamentarium of drugs and techniques for use against pain, the committee believes that were existing and available skills and knowledge to be appropriately applied now, immediate and striking improvement in the treatment of patients in pain would result.

In the last few years, efforts have been made in some centres in Canada to improve the treatment of chronic pain. These include Palliative Care Units, pain clinics, and out-patient oncology clinics. Changes in teaching programs at pre- and postgraduate levels in a few medical schools suggest some increased interest in the areas of pathophysiology and pharmacological treatment of pain. However, there is still little evidence that attitudes have actually changed much toward pain and its management. While the Committee, in addressing the question of the management of severe, chronic pain, focused its attention primarily on the effective treatments for such pain and the extent to which Canadian physicians know about them, there is evidence that some Canadians will not receive adequate pain control, even if these two conditions are met, because of geographic and social factors.

Therefore, the deficient pain control experienced by some cancer patients is not related to a lack of availability of heroin but to inadequate application of existing knowledge, inappropriate attitudes, and lack of access to appropriate pain services.

Improvement in pain control can occur through the dissemination and application of current knowledge and treatment tactics. If heroin were available in Canada, the fundamental causes of inadequate pain control would not be changed. The committee believes that there is no medical need to make heroin available in Canada at this time. Rather, priority should be given to improved education and training of health professionals, and pain service development. Marketing of a high-potency formulation of hydromorphone or morphine acetate would meet the limited need for a high-solubility, high-potency, injectable analgesic. Methadone is already available in Canada and may also be used.

What are the reasons for inadequate pain management?

No clinical epidemiologic study has been done in Canada to determine the incidence of inadequate management of chronic severe pain in cancer patients. Nor has there been a systematic determination of the etiology of less-than-optimal treatment. Such information should be gathered. Whatever the causes of sub-optimal care, clinical experience and the medical literature are remarkably consistent in their judgement that treatment failures occur and that most such failures are preventable. Inadequate pain management is due to:

● *Inadequate application of available skills and knowledge*

Immediate and striking improvement in the treatment of patients in pain would result if existing and available skills and knowledge were optimally applied.

● *Entrenched attitudes and behaviors in the health care professions*

Despite recent innovations such as palliative care services, pain clinics, and out-patient oncology clinics, there is still little evidence that attitudes have actually changed much toward pain and its management. Several factors conspire to keep changes in our professional attitudes well behind the advances in knowledge of pain and its management.

● *Lack of access to or availability of pain services*

Some Canadians may not receive adequate pain control because of geographic, social, and other related factors such as linguistic and financial barriers, and ethnic, religious, and cultural backgrounds.

While many patients with severe chronic pain may be effectively cared for within the existing services, the provision of special pain clinics, so situated as to provide accessibility to all Canadians, is essential if optimal care is our goal for the future. Expanding computer, telephone, and television satellite communications systems make this feasible.

Strategies to improve pain management

● *Education and training*

Undergraduate professional education

Studies documenting inadequate pain control repeatedly identify lack of knowledge about drugs and other available modalities, as well as the presence of certain counterproductive attitudes about pain, as the cause of inadequate treatment. Undergraduate education should afford students opportunities to acquire essential knowledge, to learn the necessary skills, and to have an opportunity to practise them under the supervision of knowledgeable and skilled preceptors. Students should see appropriate attitudes and behaviors displayed by their teachers in a treatment setting.

Postgraduate medical training

Undergraduate teaching must then be reinforced and enhanced in formal postgraduate training programs. The deficiencies in postgraduate and undergraduate education about pain may arise in part from the fact that its management is "nobody's specialty" and therefore "nobody's reponsibility."

Optimal pain management may require an extraordinary degree of multidisciplinary interplay and coordination. In a sense, therefore, the difficulty in taking advantage of existing techniques and knowledge is an organizational failure. Those clinical specialties in which pain is a particularly frequent clinical problem should have didactic teaching in greater depth than those specialties in which pain customarily is not a major component of practice.

Physicians and surgeons responsible for teaching and supervising residents in postgraduate training programs must become more aware of the problem of pain, more responsive to the patient with pain, and more expert in managing pain, in order that they may serve as role models for those under their supervision. This would have to be realized through increased awareness and educational upgrading of these supervisors.

Continuing education of medical, nursing, and para-medical personnel

It is essential that the continuing professional education of existing physicians, nurses, and para-medical personnel be given high priority. This will not be an easy task for a number of reasons, including: the large numbers of professionals involved; the difficulty in establishing effective continuing education; and the difficulty of changing entrenched behavior.

Recommendations

• A brief, readable pamphlet designed for physicians and other health care professionals be prepared to make them aware of the essential elements of modern pain management. Such a pamphlet should be distributed widely. They should be informed that a more detailed monograph is also available.

• A monograph on the control of cancer related pain be widely distributed to Canadian physicians and, upon request, to other health care personnel and interested individuals and groups. Such a monograph should be updated at appropriate intervals.

• This report be distributed to appropriate ministries of provincial governments; faculties of medicine; schools, faculties, or colleges of nursing; faculties of pharmacy; and national and provincial organizations responsible for or interested in undergraduate, postgraduate, and continuing education.

• Institutions and organizations concerned with health care be encouraged to review their current education programs and, where needed, seek ways and means to augment the exposure of trainees to comprehensive pain control at undergraduate, postgraduate, graduate, and continuing education levels.

Public Education

For three reasons, any program to improve the management of severe chronic pain in Canada must include public education. First, in North America there is an increasing demand by the public that they be informed about issues involving personal health care, and that such information be derived from the most authoritative sources possible. Second, the need for a public education component is important since the public has recently been made aware of controversy concerning the management of pain. Third, public education can have an important supplemental benefit since it will heighten the awareness of physicians and other interested groups about pain management.

Recommendations

In consideration of the current interest in pain control in Canada, we recommend that:

• A pamphlet be prepared to inform the general public about modern pain control measures in cancer. Such a pamphlet should be widely distributed through government, professional, and lay groups.

• Copies of this report be widely distributed and made freely available to public service organizations, consumer groups, advocacy groups, the media, and provincial agencies.

● *Development and implementation of pain treatment services*

In most situations, any well-informed and conscientious physician can provide effective treatment for pain using available analgesics, ancillary medications, and appropriate psychological support. Assistance may be needed in more difficult situations when the etiology of pain is not clear, when pain does not respond to usual measures, or when technical skills are required either for treatment of the underlying disease or the symptomatic control of pain. In these circumstances assistance must be available in the form of specialized pain services.

The extent of the problem of difficult pain management has not been accurately defined for Canada and data do not appear to be available from other sources to permit a recommendation as to the number of such units which should be made available. It would seem practical, however, to suggest that such comprehensive multidisciplinary facilities be available in tertiary care hospitals in each region.

Recommendations

• Federal support be given to support health care systems research that will result in development of models for effective and efficient local, regional, and provincial pain treatment services.

• Based upon identified need, health care institutions be encouraged to participate in the establishment of regionally based and coordinated networks of services for management of pain. Such services should incorporate diagnostic as well as multidisciplinary treatment components. In this context, consideration be given to encouraging development of regional pain services by identifying mechanisms whereby joint federal and provincial planning can occur.

• Guidelines for development of 'Pain Treatment Services' for cancer patients be prepared similar to those prepared by the Department of National Health and Welfare for other types of health services or facilities (eg, "*Palliative Care Services in Hospitals*," 1981).

● *New drugs: A role for heroin?*

All reports reviewed indicate that there is no clinically important difference in the effectiveness of morphine and heroin taken by mouth.

It is clear from the studies cited that an oral morphine solution will, when used with a variety of adjunct approaches, control the pain due to advanced malignant disease in more than 90% of patients with pain. It is in the remaining patients that there may be a potential role for heroin.

For a very small number of cancer patients who have pain, and where the intravenous route is not selected, there is a need for an agent which permits small, volume-high dose intramuscular or subcutaneous injection. What alternatives are there for the occasional patient requiring such high dose, subcutaneous or intramuscular narcotic injections, for whom heroin would be considered if it were available in Canada? The current available options include:

a) The sublingual or rectal administration of morphine.

b) Methadone. Methadone is a potential alternative to heroin for intramuscular or subcutaneous administration because of its solubility (1 gram in 12 millilitres water) and long analgesia time (up to eight hours) and half-life (about 15 hours). Knowledge of the relatively complex pharmacokinetics of methadone is required for its safe utilization. Recent studies have proposed an apparently safe dosing regime for this drug. A special licence to use this drug is required but readily available.

Other options include:

a) Hydromorphone hydrochloride, a potent analgesic, is currently marketed in Canada as a 2 mg/ml solution. The solubility of the drug (1 gram per 3.0 ml water) suggests a higher concentration solution could be relatively easily prepared. A 10 mg/ml solution of hydromorphone has recently been approved in the United States, suggesting it may be soon available in Canada.

b) Morphine acetate, as a highly soluble alternative (ie, 1 g in 2.5

(See — Pain management — page 10)

THE BACK PAGE

Vol. 13 No. 12 2nd Class Mail Reg No. 2776 TORONTO December 1, 1984

Holiday Greetings

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

INDEX OF HEADLINES FOR 1984

The centre section

'Every day another 274 premature deaths'

Ban all tobacco promo, UK docs implore

By Alan Massam

LONDON — The British Medical Association (BMA) has launched a spectacular attack on tobacco sponsorship which surprised even hardened and cynical journalists with its power and conviction.

The press was invited to BMA headquarters to see an exhibition of promotional material put out by the tobacco industry.

Then came the broadside. "We believe that all the promotional material in this room should be made illegal," said association secretary John Havard.

"The tobacco industry spends millions of pounds employing advertising, public relations, and promotional experts to help them promote a product we know — and they should know — is directly responsible for disease, illness, and death.

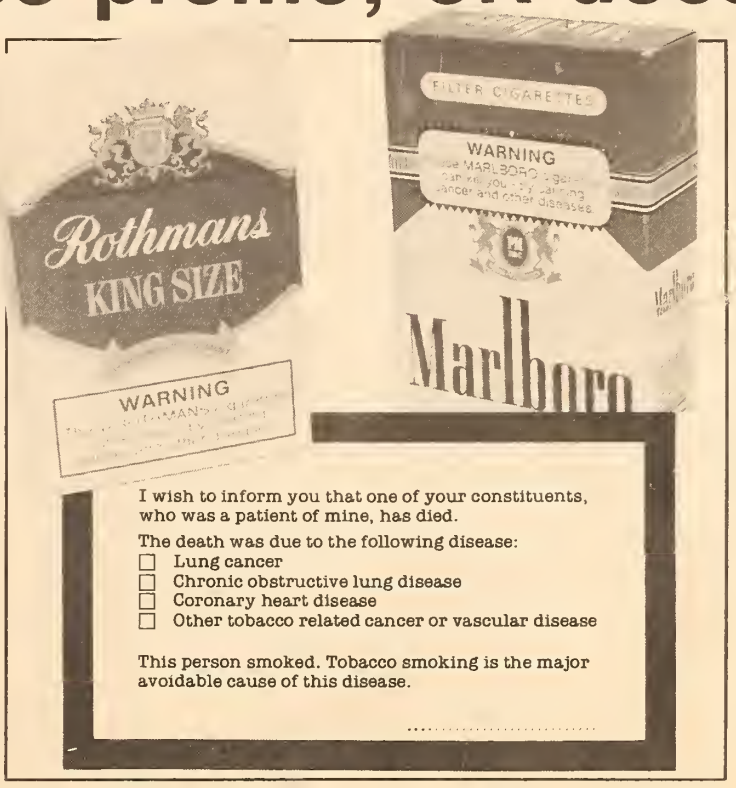
"Advertising, sports and arts sponsorship, competitions, clothes bearing brand names, and holidays are all part of the industry's attempt to fool their consumers into believing smoking is glamorous, healthy, and desirable.

"These same consumers are our patients, and we know the truth — that smoking causes appalling illness and so many unnecessary deaths that the figure of 100,000 premature deaths a year is almost beyond comprehension.

"Tobacco companies are responsible for a massive cover-up exercise carried out world-wide by an industry which callously ignores the medical facts. They are determined, by their highly sophisticated promotional activities, to persuade millions of people to ignore the appalling health hazards, lulling them into a false sense of security by associating their products with healthy activities."

Dr Havard was uncompromising. "It has to stop," he said. "We intend to push to outlaw tobacco advertising and tobacco sponsorship. Every day we delay in banning the promotional activities of this industry, another 274 premature deaths occur."

Counterattack: harsh messages to legislators and smokers ——▷



Dr Havard said the association's strategy for achieving its objective includes encouraging all family physicians to write to their local members of parliament when a constituent dies of a smoking-related disease. The doctor's letter would simply say: "One of your constituents died today. I am writing to tell you that his death was premature and was caused by smoking."

Dr Havard was backed by the head of the association's professional division, John Dawson, who said doctors want a realistic health warning on cigarette packets.

"The current health warning is a scandal," Dr Dawson said. "Tucked away on the side of the packet is 'Cigarettes can seriously damage your health.' Those cigarettes can kill people."

The BMA wants to see health warnings on the front of packets linking the brand name with the deaths they cause from cancer and other diseases. These warnings would tell the truth and the BMA believes the department of health and social security has a responsibility for enforcing this.

"It is not our aim to take cigarettes away from old people, who are dependent on them. This is not a campaign against the individual smoker — it is a campaign against the tobacco industry. We must help people to resist the pressures to start smoking and that means protecting children. It is the kids who start smoking, rarely the adults."

Dr Dawson added that the BMA wanted to see the Health Promotion Trust closed down. The trust had been set up by the tobacco industry to carry out medical research into everything except the deaths and disease caused by smoking. The money should be channelled into medical research free from direction by the tobacco industry, he said.

Europeans probe drugged driving

By Harvey McConnell

STOCKHOLM — The number of people driving while under the influence of cannabis is considered a growing problem in Sweden and West Germany.

A Swedish study suggests that drivers who lost their licences for cannabis offences — most of them in their 20s — show long-term memory deterioration and difficulty in concentration.

West German officials, worried about the number of cannabis-inhibited drivers living in the area bordering The Netherlands — where drug laws are more liberal — will open a pilot treatment program in early 1985 in the frontier city of Aachen.


Persson: additive effects

Eva Persson, a psychologist at the Narcotic Addiction Unit at Huddinge Hospital, Stockholm, told an international workshop on driving under the influence of alcohol and other drugs that the way cannabis-impaired drivers see themselves, and the way the researchers found them, are quite different.

In the past 18 months, she and her colleagues have studied 45 drivers, five of them women, who were seeking reinstatement of their drivers' licences following cannabis violations. A psychological assessment is part of the routine required by the licensing authority before a licence is returned. All but five of the drivers were aged between 19 and 29 years (the oldest was 57).

Mrs Persson told the workshop, sponsored by The International Committee on Alcohol, Drugs and Traffic Safety, that 18 of the drivers had used only cannabis while the rest combined cannabis with alcohol or other drugs. Most had used cannabis for a long period of time; 14 had used it for between six and 10 years, and seven for more than 10 years.

Twenty-two of the drivers had stable jobs. "And what did surprise us was that eight of them had positions as professional drivers," Mrs Persson said.

Researchers were also surprised that all of those studied "see themselves as drug-free when driving, unless they have taken drugs immediately before getting behind the wheel."

Researchers noted that while guidelines about cannabis and drivers' licences are needed, more information is also needed about the role of "cannabis in traffic" and about the long-term effects of cannabis. "Our clinical impression is that cannabis abusers seem to deteriorate in memory, decision-making, and endurance.

"The additive effects of cannabis and alcohol make it even more clinically difficult," she added.

Although some drivers said they consumed only small amounts of cannabis at a time, Mrs Persson said the THC (tetrahydrocannabinol) levels in the system had built up to high, steady states.

The researchers suggest drivers be drug-free for at least six months, as judged by periodic

(See — Cannabis — page 2)

More honesty in drug education would go further with kids

By Terri Etherington

TORONTO — Scientists and drug educators would gain credibility with young people if they admitted drugs can be fun and make people feel good, says Ron Clavier, clinical psychologist at the Clarke Institute of Psychiatry here.

"It is not necessary to talk about the harmful effects of marijuana or cocaine. No one wants to hear that," he told a drug abuse and youth conference.


Clavier: dealing head on

"Let's not make the mistake of assuming that kids in school have not heard that drugs are harmful."

They've heard it before, and that doesn't stop them, he said.

The sooner drug educators realize that drugs are fun, and "deal with that head on, the more chance we have of making a meaningful impact," Dr Clavier said.

He said one place to start is in the classroom with detailed, science-based drug education that is non-threatening and non-accusatory.

For instance, in a biology class, the science teacher could talk about how substances are absorbed in the body, how they are distributed, what is left behind physiologically and biologically, what the break-down product is, and how the cell responds to the accumulation of that product.

"It is time that information found its way into the classroom so young people can assess it and understand it."

Dr Clavier said it is important to tell students that the sensation of feeling good produced by drugs is an illusion prompted by a chemical imbalance in the brain.

Are parents being duped by expensive treatment promises?

See — Parents — page 2

Science lessons could deal with how complicated and delicate the brain is, and how small deviations in the chemical balance of the brain can have serious consequences.

"The brain uses chemistry to communicate. It uses chemicals to take us from reality, or the environment, to our subjective experience," what we think is happening, Dr Clavier tells students.

A chemical imbalance can mean the brain is responding to an illusion. Talking about drug taking as the "wilful onset of chemical imbalances" may be a better way to

(See — Drugs — page 2)

INSIDE

NEWS

Briefly...

Bonus to farmers

TORONTO — Almost $13 million in subsidies will go to Ontario's 2,000 tobacco farmers caught in the economic squeeze of dwindling exports and falling domestic sales. The hand-outs — $1.6 million from the Ontario government and $11 million from the cigarette manufacturers — are welcome, but they are not enough, the chairman of the tobacco growers' marketing board told *Canadian Press*. The organization is also calling on government to cut taxes on tobacco products.

Heroin as medicine

TORONTO — The Ontario Legislature passed a unanimous motion urging the federal government to legalize the therapeutic use of heroin. The motion calls for an amendment to the Narcotics Control Act allowing terminally ill patients access to heroin. According to a *Globe and Mail* report, MPP Robert Runciman (PC), in support of the motion, said the decision to ban the prescribing of heroin for the terminally ill was political, not medical.

Alcohol controls

LONDON — The British Consumers Association is calling for increased liquor taxes, scrutiny of wine and beer ads, and more anti-alcohol education programs to combat what it says is a serious rise in alcohol-related accidents and crimes. *The Toronto Star* reports that, in a brief to the government, the organization claims alcohol "is responsible" for nearly one-third of road deaths and costs the country nearly $2 billion a year in illness, accidents, and work loss.

Odor is possession

FREDERICTON — A man whose breath smelled of marijuana has been fined $200 for possession of the drug. Police saw the man smoking what they thought was a marijuana cigarette, but found nothing when they searched him. A footprint led to a nearby riverbank where 17 grams of marijuana were found. While the appeal court judge ruled the footprint was insufficient to convict the suspect, the judge said, "you can't have the smell of marijuana on your breath unless you have it in your lungs," and that amounts to possession, *Canadian Press* reports.

Smokers work harder

ST PAUL, Minn — Smokers may be addicted to more than just cigarettes, a study here found. The investigation of bank executives found that smokers are slightly more productive than their non-smoking counterparts and are 2.5% more effective in making the best use of their time. Possible reasons, researcher Tor Dahl of the University of Minnesota told the *American Press*, are that smokers tend to have addictive personalities "and may well be addicted to their work," and that smoking has a temporary stimulating effect.

US private treatment can be expensive

Parents warned against 'magic cures'

By Harvey McConnell

WASHINGTON — Many parents of children with drug abuse problems face being duped into expensive treatment which will last as long as private insurance payments hold out.

This is why there is a continuing need in the United States for community-based programs, said Shirley Coletti, chairman of the board of the National Federation of Parents for Drug-Free Youth. Private hospitals can be expensive, she told the federation's annual conference here.

Mrs Coletti: "I feel we are about to be duped" by smooth-talking sellers of "the magic-cure, 28-day program." This really means the seller is saying "for $4,000, $6,000, $20,000, I can cure your kids in 28 days, that is, as long as your insurance pays for it. Now when your insurance runs out, we are not going to be able to work effectively with that youngster any more."

She added: "This means they are going to be dismissed or discharged."

Mrs Coletti said parents should resist these high-pressure sales efforts and should not accept the claim that such treatment is the solution. The demand should be for day care services, outpatient services, and long-term residential care, because in some cases "the need is for habilitation not rehabilitation."

While there is a place for free-standing, private alcohol and other drug program facilities, "there is also a need for community-based programs, and I have strong feelings about community-based programs," Mrs Coletti added.

Canadian hero loses out on drug message for kids

TORONTO — Mr T has beaten out Wayne Gretzky as the person chosen to introduce an anti-drug videotape for Ontario young people.

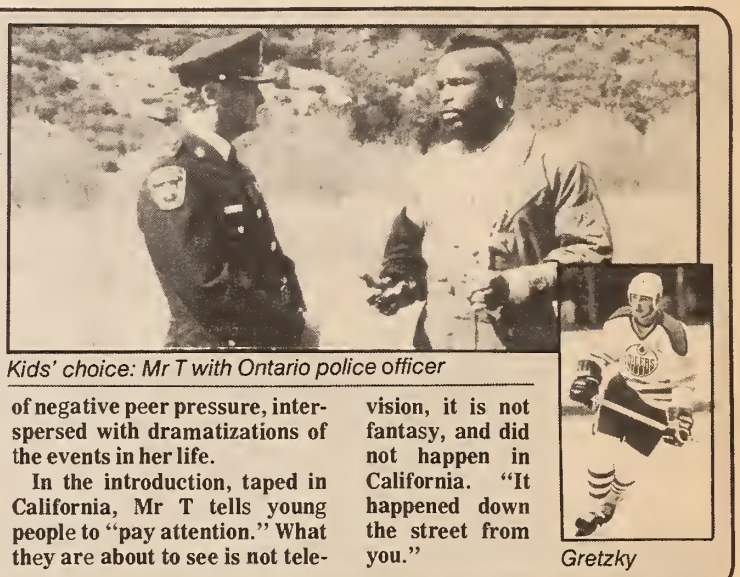
Mr T is the muscle-flexing, jewel-bedecked anti-hero of a United States television series heavily laced with mad car chases and brawls; Gretzky is the goal-scoring, fast-skating superstar of Canadian hockey.

"We could have got Gretzky," says Superintendent Barry King of the Peel Regional Police, but a poll of area schools showed kids preferred Mr T.

The program — With Friends Like That — is aimed at nine to eleven year olds and was sponsored jointly by the Ontario Association of Chiefs of Police and the ministry of education. It will be released next month to police stations in Ontario.

Supt King showed the tape at a drug abuse and youth conference held here as part of Ontario's Addiction Awareness Week. It features commentary by a young Ontario girl who got involved with drugs as a result of negative peer pressure, interspersed with dramatizations of the events in her life.

In the introduction, taped in California, Mr T tells young people to "pay attention." What they are about to see is not television, it is not fantasy, and did not happen in California. "It happened down the street from you."



Kids' choice: Mr T with Ontario police officer

Gretzky

Britain earmarks £8 million to battle heroin

By Alan Massam

LONDON — The British government has taken major steps toward resolving the nation's growing drug problem.

Health Minister Kenneth Clarke chose the Conservative Party's conference in Brighton to announce that he had authorized the spending of a further £5 million (approx Cdn $8.25 million) on "prevention and other measures."

This brings to a total of £8 million the amount the government has earmarked this year for a campaign aimed at the heart of the heroin epidemic (**The Journal**, October, August).

Officials hope that by taking steps to stem the importation of illegal heroin into the UK and by educating young people on the perils of starting the habit, the growth of abuse can at least be contained.

A consultant psychiatrist who has specialized in drug addiction problems for many years, Dr Martin Micheson, said just after the Brighton conference that it was impossible to estimate the number of heroin users in Britain as many went on for some years before seeking help. At his clinic in central London, however, the number of referrals annually had increased by 600% over the last five years.

A recent Home Office statistical bulletin reveals the worrying figures which prompted Mr Clarke's speech in Brighton. It says that the upward trend in the misuse of drugs began in 1976. The number of seizures of controlled drugs increased by 21% (4,600) between 1982 and 1983 which was greater than the percentage increase of any of the previous seven years.

The bulletin adds there was a 32% increase in street seizures in 1983 following large increases in the previous two years. This brought the 1983 street seizure figure to about 11,300 as compared to 8,600 in 1982 and an annual average of about 4,000 in the years 1974 to 1978.

Most of the seizures involved class B drugs like cannabis, but there was a proportionally larger increase of seizures of class A drugs like heroin which went up in 1983 by 41% to about 3,800.

In a statement in October, Mr Clarke announced that he was publishing a report of his Medical Working Group on Drug Dependence called *Good Clinical Practice in the Treatment of Drug Misuse*.

He said he welcomed the report which recommended that all doctors should have responsibility for providing care for drug misusers.

It gives them "valuable and detailed guidance about treatment" and explains how they should consider all the needs of the patient, as well as tackling the particular drug misuse problem.

Mr Clarke added: "The guidelines emphasize the need for careful diagnosis, and provide advice on assessment and the need to agree on the appropriate treatment with the individual patient.

"They stress the importance of a cooperative approach with other statutory and voluntary agencies and the involvement and support of the family and friends of the drug misusers, because medical care must be one part only of the process of tackling all the person's problems in every possible way."

Drugs a short cut to feeling good

(from page 1)

reach young people, "without talking about how bad marijuana is or how many people use heroin."

But, Dr Clavier said, educators "need to point out that (taking drugs) short-circuits all other mechanisms of feeling good."

He tells young people that putting in hours preparing a science project, writing a poem or play, or practising for a winning football game are all ways of feeling good. "But why take the trouble, when you can just short-circuit that by sitting at home and listening to music or drooling in your shoe? Why bother to take the time?"

People take the time because "that other way — the short circuit — is an illusion, and if you start responding to the illusion, you will make errors in judgement," Dr Clavier says.

The ultimate error in judgement is an error in the perception of self. "If you respond to an illusion of yourself as better, classier, funnier, smarter, more able to appreciate music, more able to experience your environment, you will think more of yourself. But you are responding to an artificially-induced ability. In fact, your actual ability is not changed at all."

Dr Clavier cautioned conference delegates: "When you ask the question 'who do you think you are' to a kid taking drugs, you'd better listen to what the answer is, because they are going to be behaving according to who they think they are, where they think they are, and what they think is happening."

The conference was sponsored by the Drug Education Coordinating Council as part of Ontario's Addiction Awareness Week.

Cannabis/driving studied

(from page 1)

urine tests, before authorities consider renewing their driving licences.

Markus Jensch, director of a clinic in Cologne, has been asked to set up the pilot program in Aachen to study cannabis-impaired drivers. He said there is an immense problem in the areas of cannabis consumption, dealing, and smuggling, and in concomitant crime.

The pilot program will treat patients for at least a year, and the service will include lengthy sessions aimed at teaching people coping skills and strategies.

"We want to look at more than just their cannabis consumption. Why do they do it and what help can we give them with their problems?"

Dr Jensch said he has worked with more than 700 drunk drivers since 1957, with the aim of counselling and finding the root cause of the problems which lead to excessive drinking. He would like to do the same with cannabis users, but he recognizes there may be many problems.

"Many experts believe the Scandinavians are years ahead in treating the social drinker who drives," writes Contributing Editor Harvey McConnell from Stockholm. In the January 1985 issue, Mr McConnell will report further on an international workshop in Stockholm on alcohol, other drugs, and driving.

NEWS

'Societies gone wrong defy individual pursuit of health'

By Alan Massam

LONDON — The idea that individuals are responsible for their own destiny should not be used to justify inaction or insufficient action by a society faced with drug addiction.

The hint for some of Britain's politicians comes from a leading academic in the field, Griffith Edwards.

Dr Edwards is director of the addiction treatment unit, Maudsley Hospital, and professor of addictive behaviors, Institute of Psychiatry here.

In his Upjohn Lecture to the Royal Society, he referred to the lines of William Ernest Henley (1849-1903):

It matters not how strait the gate
How charged with punishments the scroll,
I am the master of my fate;
I am the captain of my soul.

The lines are "relevant . . . because they can assist us to understand the thinking of government departments," he said.

For example, in 1976, the department of health and social security declared that "much of the responsibility for ensuring his good health lies with the individual . . . ."

Dr Edwards agreed it would be a sad day if individuals surrendered responsibility for their health, but there is a step-wise relationship between increased mortality expectation and membership in less privileged social class.

"The array of conditions for which this general statement holds true is startling," he said.

To epidemiologists, the relationship between mortality rates and class are too familiar; most people — whether white collar, blue collar, or no collar — do not bother "that collars are a matter of life or death."

Mortality figures indicate that people are born into health privilege or lack of health privilege. Against the figures, "Henley's easy rhetoric begins to look a little incomplete."

Dr Edwards said his context was the argument that addictions are a challenge to society and not just to the individual. He agreed that there is not one explanation for social casualty, that no one master stroke of social engineering would build Jerusalem and banish addiction.

"What we are, though, firmly arguing is that addictions are examples of the very general truth that a wide range of socio-economic influences — influences which are society's responsibility and which are a challenge to society — bear on the individual's capacity to handle his or her inalienable personal responsibility."

The central issue is how society is to act in support of the individual and ensure that he or she is not overwhelmed by social influences beyond his or her control.

Dr Edwards said cigarette smoking is estimated to contribute to 100,000 premature deaths in Britain annually, yet "sports sponsorship by cigarette manufacturers" drives a coach and horses through the (British) ban on television advertising of cigarettes.

"The boy standing in the corner of the playground and about to accept that first offer of a cigarette is unlikely to have read the reports of the Royal College of Physicians," Dr Edwards said. "He and his sister may, though, have watched last night's snooker or last Saturday's car racing on television, or, on their journey to school, they may have passed a good many hoardings (outdoor advertisements) which subtly conveyed messages such as that cigarettes offer magical identification with a rugged cowboy.

"It is disingenuous to claim that this massive advertising assault is likely to be confined in its impact solely to switching of brand loyalty.

"If that lad in the playground can be wooed into the start of a smoking career, he is all too unlikely to quit. Nicotine is a highly addictive drug."

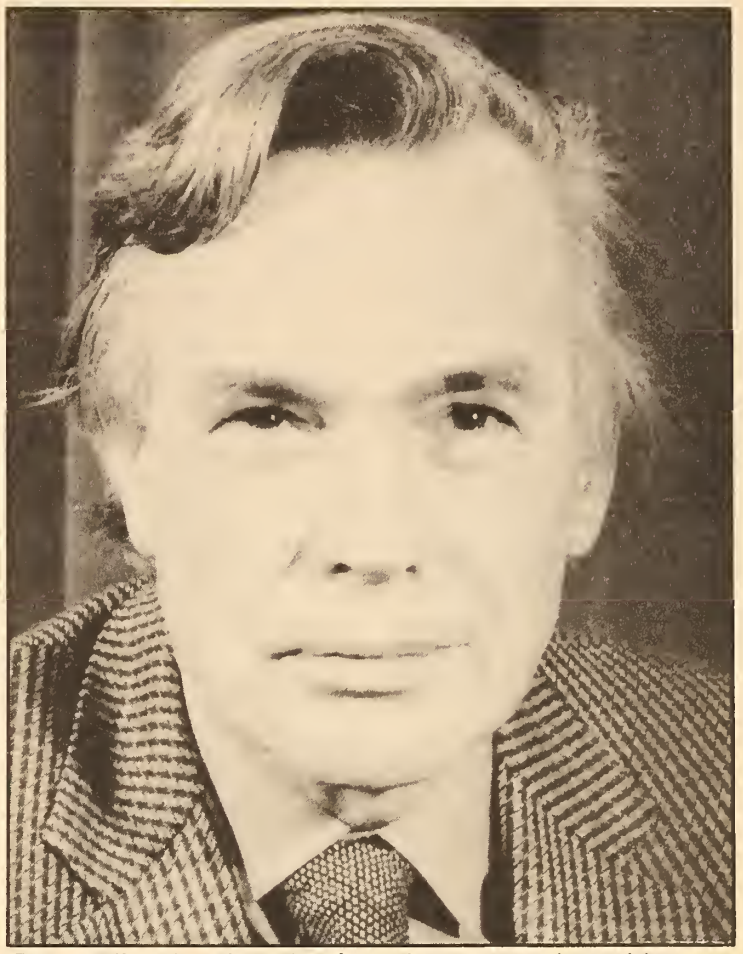
Dr Edwards gave similarly hard-hitting observations on cannabis, tranquillizers, alcohol, and heroin. He said few would blame the young heroin user for lack of proper captaincy of his or her soul. Whatever the sum of partial explanations, the audience was left with the suspicion that part of the answer might lie nearer home than the poppy fields of Afghanistan.

"What sort of lives have we been offering to young people that they find heroin alluring? We have coexisted not only with drugs, but also with the evidence that young people in many areas of this country are being brought up in failing cities and reared to unemployment."

He added: "No one who has examined the historical and international story of drug problems and drug epidemics would doubt that supply is important to the equation. Similarly, no informed enquirer could doubt that if you breed people to frustration or, worse still, sheer hopeless passivity, you put our society at risk of heroin or glue or any one of a dozen other chemical manifestations of a society gone wrong . . . .

"If we are to deal more effectively with the manifold problems set by mind-acting chemicals, we must hope for a 21st century which both honors individual freedom and, at the same time, accepts more boldly the responsibility for building a social environment within which the individual can exercise freedom and enjoy health.

"Those who from secure positions preach freedom of choice should be very sure that they are not merely subverting the slogan of freedom in defence of drift, neglect, profit, revenue gathering, and exploitation."



Edwards: If you breed people to frustration you put society at risk

Australia urged to legalize medical heroin

CANBERRA — The Human Rights Commission here will recommend to government that heroin be made available for relief of chronic pain in terminally ill patients.

Dame Roma Mitchell, chairman of the commission, said special consideration should be given to the rights of terminally ill cancer, patients, including leukemia victims, who often go through a "dehumanizing process during their illness," as a result of severe pain.

In a recent press release, Dame Roma said the commission will recommend that such patients be allowed to choose heroin for effective pain relief.

"Medical researchers do not understand why patients respond differently to particular narcotics," Dame Roma said.

"There have been a number of inquiries in Australia about the use of heroin, but no conclusions have been reached," she said. "In the meantime, people who might have been able to obtain some relief are dying in great pain without recourse to the drug."

Trial balloon deflated

BC groups nix grocery wine, beer

By Tim Padmore

VANCOUVER — A hail of angry darts has deflated a trial balloon floated earlier this year to test the idea of allowing sales of beer and wine in grocery stores in British Columbia.

Since Consumer and Corporate Affairs Minister James Hewitt remarked in July that "it would be fair to say that in the not-too-distant future there will be sales of beer and wine, or at least wine, in the grocery stores," public and private interest groups have been lining up to shoot down the idea.

Metropolitan Health Services, the BC Government Employees Union, the Alcohol-Drug Education Service, the Downtown Eastside Residents Association, the Vancouver Police department, Mothers Against Drunk Driving, the Seniors Alcohol and Drug Rehabilitation Society, and the city councils of Vancouver and Saanich have all gone on record as opposing sales from corner stores.

Nor is the industry altogether enthusiastic. Alan Branston, vice-president and general manager of Carling O'Keefe Breweries Canada Ltd here, said he is satisfied with the present system of distribution and fears the cost of delivering to an estimated 8,000 additional outlets.

Mr Hewitt's ministry commissioned a summer survey of public opinion on the issue. The results have been submitted to the minister, but so far no details have been released.

Contemporary readers want dope on drugs

By Wayne Howell

My dearest Nephew:

Thank you for your recent missive which I received co-incident with the packaged manuscript a fortnight past. I was sorry to hear that Blotchner, Sleaze, and Bellweather had rejected the manuscript, and I was grieved to hear of the depths of despondency to which this rejection has driven you. Cheer up. Many literary luminaries — such as James Joyce and George Orwell to name just two — have had difficulty finding a publisher for their work.

Personally, I found *Babylon Relived* an interesting and engaging work. But notwithstanding that, I hope you will not reproach me when I say that I could not help agreeing with the B, S, and B editor who concluded, "despite the book's many virtues it lacks a contemporary focus." It is apparent from your letter that you are puzzled by that remark. Perhaps I can assist you in your revisions by elucidating what I think the editor meant.

You set out to write a best-selling novel about Hollywood personalities and rock stars. Your first instinct was sound: base it on the lives of real people, adding just enough fictional spice to the stew to prevent nasty, time-consuming, money-consuming lawsuits. The public loves a *roman à cléf*.

Your second instinct was just as sound: base it on the sex lives of your "fictional" characters. The public loves a *roman à lubricité*. And in that regard I must congratulate you; the sexual couplings in *Babylon Relived* are most intriguing, and the alternations of hetero and homo, straight and kink, set up a pleasing contrapuntal rhythm of conjoining pudenda that is to prurience what Bach was to music.

Your third instinct — that your protagonist's child is born with a venereal disease — was also sound. Those who live life in the collector lanes love to read about the sexual lives of those who live life in the express lanes — but they expect a moral at the end, something to the effect that the wages of sin are grief.

So why, then, does *Babylon Relived* lack a "contemporary focus" as the editor put it? Quite simply, dear nephew, you have not paid proper attention to drugs. Oh, I know, the characters in *Babylon Relived* drink a lot, and there are one or two pot-smoking scenes, but the whole thing is, well, vague and unquantifiable — pharmacologically mushy. You must realize, dear nephew, that the drug habits of the rich and the famous are the new pornography.

Witness the commercial success of *Wired*, Bob Woodward's account of the late John Belushi's life. Witness the success of *Chasing the Dragon*, the story of Cathy Smith, the woman who allegedly administered Belushi's last fix. Witness the successful drug-oriented, drug-obsessed biographies of Lenny Bruce and Elvis Presley. The reading public is jaded with tales of sexual congress, no matter how bizarre or intriguing they might be. It is drug-lives, not sex-lives that capture the imagination.

I think you could tighten up your manuscript a great deal and give it the contemporary focus it lacks by giving more "factual" details about the drugs used — where obtained, prices paid, subjective effects, that kind of thing. And don't feel you always have to mix drugs with sex: remember that drugs can be an end in themselves, and contemporary readers are just as fascinated with a good drug tale as a good sex tale, perhaps even more so. And you can still moralize at the end; instead of VD an OD perhaps. I leave that to you dear nephew, you are the creative artist in the family, not me.

All the best,

Your loving Uncle

NEWS

RESEARCH UPDATE

Urinalysis detects passive pot smoke

A positive result from urinalysis does not necessarily mean a person has smoked marijuana, a British study has shown. In a laboratory study which attempted to duplicate conditions of social marijuana use, researchers showed that passive inhalation of marijuana smoke can lead to significant urinary cannabinoid concentrations. Six volunteers each smoked a marijuana cigarette containing 17.1 milligrams delta-nine tetrahydrocannabinol (THC) in a small, unventilated room at the same time, while a further four non-smokers remained in the room during smoking and for another three hours. While blood samples of the passive smokers showed a complete absence of THC metabolites, urine samples showed concentrations of cannabinoid metabolites of about 5 ng/ml^{-1}, using an assay in which a finding of more than 2 ng/ml^{-1} is taken as a positive indication of marijuana use. The researchers, from the Home Office Forensic Science Service, Reading, and the department of biochemistry, University of Surrey, Guildford, stated that the results of this study and other work "highlight the problems faced by forensic toxicologists in the field of cannabinoid analysis of biological fluids."
Journal of Pharmacy and Pharmacology, Sept 1984, v.36:578-581

Disulfiram danger for children

Disulfiram (Antabuse), a drug commonly used to treat alcoholics, can cause serious illness if accidentally used by children, say two California researchers, who warn that childhood intoxication caused by the drug may be underdiagnosed. While disulfiram is relatively non-toxic in adults and causes only unpleasant symptoms when alcohol is ingested after its use, William Benitz, MD, and David Tatro, PharmD, of the Stanford University Medical Center, Stanford, Cal, said that of the seven reported cases of children who accidentally took the drug, one died, and three suffered moderate or severe brain damage. They said such intoxication is hard to diagnose in children because the symptoms of lethargy or somnolence, weakness, hypotonia, and vomiting are common in children and do not correspond to the symptoms of chronic intoxication in adults. Disulfiram is not detected by routine toxic screening techniques, they said, and there is no specific treatment for the condition. These treatment problems, the study said, are compounded by the fact that disulfiram is used for alcoholism on a widespread basis in settings of unemployment and marital discord, where accidental poisoning in children is prevalent. Drs Benitz and Tatro urge increased awareness of the symptoms of disulfiram intoxication in children to allow more frequent diagnosis and, in turn, consideration of therapeutic measures.
Journal of Pediatrics, Sept 1984, v.105:487-488

Neonatal ethanol withdrawal

Newborns can show symptoms of alcohol withdrawal even if they do not have fetal alcohol syndrome (FAS). That is the conclusion of a study of newborns of three groups of women who applied for prenatal care at Grady Memorial Hospital in Atlanta, Ga. Eight neonates born to women who drank a mean of 21 oz of absolute alcohol per week during pregnancy were compared with a group of 15 infants born to women who stopped drinking during the second trimester, and 29 infants whose mothers did not drink during pregnancy. While none of the 52 neonates had physical symptoms of FAS, neurobehavioral evaluations conducted during the third day after birth showed that the infants of the mothers who drank throughout pregnancy had significantly more of the characteristic signs of withdrawal from central nervous system depressants than the other two groups. These symptoms included tremors, sleeplessness, hypertonia, abnormal reflexes, and excessive mouthing, as well as inconsolable crying. Researchers from the Human and Behavioral Genetics Research Laboratory, Georgia Mental Health Institute, said the study indicated that with heavy alcohol consumption during pregnancy, even in the absence of FAS, physical dependence of the infant may develop *in utero*. They said these infants were at risk of developing other symptoms of early exposure to alcohol, such as learning problems, and at social risk because of the problems mother and child face in coping with the behaviors, such as excessive crying, associated with withdrawal.
Journal of Pediatrics, Sept 1984, v.105:445451

Smoking cessation best ulcer treatment

Smoking, more than any other factor, influences the reoccurence of duodenal ulcers, according to a large multi-centre study. Data from 370 patients in 19 medical facilities across the United States entered in a double-blind, randomized, placebo-controlled trial were analyzed to study the influence of various levels of the drug cimetidine (Tagamet) and smoking habits on the recurrence of ulcer symptoms. All of the patients in the study were adults with recently-healed duodenal ulcers. Examination of the findings showed that ulcer recurrence was more frequent in smokers than in non-smokers irrespective of whether they received cimetidine or placebo. However, over 12 months, cimetidine appeared to protect the smokers somewhat; symptoms recurred in 51% of smokers receiving placebo and in 22% of those receiving cimetidine. The rates for non-smokers were 13% and 4% respectively. "It is tempting to conclude," the study said, "that in smokers, stopping smoking may be more important in the prevention of ulcer recurrences than administration of cimetidine."
New England Journal of Medicine, Sept 13, 1984, v.311:689-693

Pat Rich

Smokers paying their way, Ont health economists say

By Betty Lou Lee

HAMILTON — Smokers are more than paying their way when their health care costs are compared to tobacco tax revenue.

Two health economists, using 1978 Ontario figures, have estimated that public funds spent on disease caused by smoking are no more than 35% of the amount Ontario smokers paid in tobacco taxes.

Greg L. Stoddart, PhD, associate professor, and Roberta Labelle, research associate, both in the department of clinical epidemiology and biostatistics, faculty of health sciences, McMaster University here, made the calculations. They were part of a larger study on economic interventions toward healthier lifestyles with Morris L. Barer, PhD, and Robert G. Evans, PhD, of the University of British Columbia.

"There exists a widespread perception that tobacco tax revenue does not cover publicly financed health care costs attributable to smoking," Dr Stoddart told **The Journal**.

"This perception is often employed as a major rationale for anti-smoking efforts in general, and specific economic disincentives or penalties to smokers, such as increased tobacco taxes or disease-related user charges."

He stressed that the analysis does not "encourage smoking or dismiss its importance as a public health hazard," nor does it recommend against raising tobacco taxes.

"It does, however, remove the 'financial externality' argument — that is that smokers don't pay their way in the health-care system — as a rationale for public policy action against smoking."

The researchers estimated Ontario residents paid $226,446,000 in federal, and $258,569,000 in provincial tobacco taxes in 1978. They called this $485,015,000 total "conservative" because it does not include the 12% federal sales tax in effect that year.

Hospital costs were calculated at $33.9 million for treatment of diseases accepted as causally linked to smoking: coronary heart disease; cancers of the lung, bronchus, trachea, and pleura; bronchitis; and emphysema. Adjustments were made for the percentage of these diseases believed caused by smoking in each age group.

Publicly-funded doctors' services to treat these diseases, with the same age-related adjustments, were estimated at $3.3 million.

The total of these two figures was almost 8% of tobacco tax revenue.

Other publicly-funded health care costs, such as drugs, research, and institutional care other than hospitals were then included, and the amount of disease attributable to smoking was increased to between 60% and 80%. Costs then totalled $113 million, or 23% of taxes.

Since 1978, a number of other diseases have been added to the list of those that may be linked to smoking: cancers of the esophagus, larynx, bladder, pancreas, and mouth; pneumonia; influenza; gastric and duodenal ulcers; and pulmonary tuberculosis. Taking these into account, Dr Stoddart estimated the total cost would be about 35% of taxes.

He pointed out that the analysis does not include other social costs, such as fire protection and fire damage, extra costs of production, such as more cleaning and ventilation, and lost productivity. Nor does it include "psychic" costs of pain, suffering, and discomfort of others.

International group to probe methods

Alcohol-casualty stats vague

By Harvey McConnell

TORONTO — Problems associated with gathering reliable statistics on alcohol-related casualties, aside from automobile accidents, are a major reason for an international conference on the subject to be held in Toronto in August, 1985.

The conference will be jointly sponsored by the Addiction Research Foundation (ARF), the United States National Institute on Alcohol Abuse and Alcoholism (NIAAA), Health and Welfare Canada, and the World Health Organization.

Norman Giesbrecht, PhD, of the ARF and a member of the steering committee, said those attending will try to evaluate what is known about alcohol-related casualties and how information and statistics are gathered in a variety of manners and settings, and provide direction for improved designs and strategies for monitoring the role of alcohol in casualties.

Specific policies and programs will be recommended for trying to curtail alcohol-related casualties.

Robert Niven, director of the NIAAA, referred to problems related to statistics at the annual meeting in Washington in October of the Alcohol and Drug Problems Association of North America.

Dr Niven said such problems probably lead to an underestimation of the impact of alcohol on society.

He said he had approached the US Centers for Disease Control in Atlanta to try to develop studies aimed at producing better data about the role alcohol and other drugs play in a variety of traumatic injuries.

They will also examine suicide. "Statistically, alcohol use is highly correlated with large numbers of suicide deaths, but we don't know much beyond that, and there is reason to think what we know . . . is unsubstantiated," said Dr Niven.

There is a need not only for better data but also for better ways in which to present data. Dr Niven noted that at one recent meeting a speaker said 89% of people in prison are there because of alcohol. Dr Niven asked him to prove it.

"There are a lot of data to show people in prison had been drinking before the act that got them into prison," said Dr Niven. "But, you can't go on to say there is a cause and effect relationship."

He said data are often used in a well-intentioned but self-serving manner and that such intellectual and methodological errors hurt the field.

Niven: self-serving data

BC under pressure to raise drinking age

By Tim Padmore

VANCOUVER — There is growing pressure in British Columbia to raise the legal drinking age to 21 years from 19.

Interest groups like Mothers Against Drunk Driving that have been calling for a change in the law now have the formal support of Vancouver City Council.

Council voted 7 to 3 in October to urge the province to raise the drinking age and to begin a public education program on the dangers of alcohol.

Earlier, council's committee on community services made a series of recommendations, including increasing the drinking age, eliminating television and radio advertising for alcohol, and requiring print ads for alcohol to carry health warnings.

October also saw a call for raising the drinking age by Roger Tonkin, MD, of the Children's Hospital here.

Dr Tonkin is a pediatrician and epidemiologist noted for a series of studies, prepared under his direction, on child mortality and morbidity in BC.

Dr Tonkin told a conference here on the anatomy of violence that changing the drinking age would cut by 28% the number of serious night-time crashes involving young people.

He said BC is enjoying a temporary respite from teenage motor vehicle fatalities, but there is an epidemic cycle of such deaths, and the province can expect the number to increase again.

In the past, the provincial government has declined to review the legal drinking age.

Thieves, druggists in high-tech war

By Tim Padmore

VANCOUVER — Both thieves and pharmacists here are adopting new tactics in the war over controlled substances under the pharmacists' care.

Some thieves, for example, practise the "ultrasonic shuffle" to evade a popular class of burglar alarms.

The alarms send out high-pitched sound waves and are triggered if the waves reflect off a moving object.

A thief who makes every movement in slow motion, however, can move about the store at will.

Pharmacies, following the recommendations of police and their professional associations, are installing alarms and better locks, limiting inventories of street drugs, and keeping their windows uncluttered so patrolling police can see if the store is occupied after hours.

Frank Archer, president of the British Columbia Pharmacists Society, which represents all but about 200 of the province's 1,700 practising pharmacists, provided these examples in an interview with **The Journal**.

Mr Archer is not happy with the situation — a war with the pharmacist caught in the middle.

Like other wars, he said, this one has escalated.

"When you could open the drugstore with a can opener and get into the cash box with a pen knife, the costs of repairing after a breaking and entering were relatively modest . . . Now a person has to knock down a cinder block wall, or they have to tunnel in from the butcher shop next door . . . and they do $2,000 damage on the way."

Pharmacists also face physical injury from armed robbers.

And there is often an unexpected psychological trauma: guilt.

"You're supposed to guard these things with your life," said Mr Archer. "So pharmacists call me and they feel incredibly guilty. Some guy came in with a gun and they gave him all the drugs he wanted and they let him walk out."

Statistics gathered by the BC College of Pharmacists, however, indicate that pharmacists are making some headway.

"The conventional wisdom is that the problem is increasing," said Linda Brown, communications coordinator for the College, "but it's not."

She cited statistics indicating a steady decline in the past few years in forgery attempts and grab thefts. Indications are that break and enter offences increased, but still remain below the level of two years ago.

As of mid-September, there had been 66 burglaries, 30 armed robberies, 15 grab thefts, 142 written forgeries (of which one-third were actually dispensed), and 22 verbal forgeries (of which only one was dispensed).

Ms Brown acknowledged that there is some concern that increased store security, which cuts down on burglaries, may lead to more armed robberies.

She attributed the substantial decrease in forgeries in part to the College's five-year-old Fanout program, where pharmacists throughout the province are alerted chain-letter fashion by phone when there is an attempted forgery.

The program not only alerts pharmacists to the names used by forgers, but also creates heightened awareness because pharmacists are continually being reminded of the problem.

The College also distributes a monthly newsletter with helpful tips on preventing drug thefts.

Mr Archer said, however, that overall costs to pharmacists seem to be increasing, evidenced by a two- to three-fold increase in premiums for the group insurance administered by the Society. The policies, which also cover fire and personal liability, now cost a typical pharmacist several hundred dollars a month.

He said the problem is that a medical problem is being treated using a "criminal model" and that further refinements in defensive technologies will not solve anything.

"You hear pharmacists talking about 'hardening the target.' That's police jargon . . . .

"You're still going to have pharmacies broken into and pharmacists injured, as long as it's tackled from this point of view."

DWD law on way out in Yukon

WHITEHORSE — Chugging a beer while chugging along the highway may soon be a thing of the past in the Yukon.

The Yukon Territory is the only area in Canada which currently allows both drivers and passengers to drink alcoholic beverages while in a moving vehicle as long as the driver is not impaired. In mid-November, the government announced that a new law banning the practice will be introduced in the spring.

"We're very pleased," said Allon Reddoch, MD, president of the Yukon Medical Association.

"We've been trying for years to promote the same legislation that's elsewhere."

Dr Reddoch said he suspects the government has finally begun to pay attention to statistics which show the Yukon has more than double the national average of fatalities and injuries resulting from impaired driving.

GILBERT

'If Dr Richman is right . . . then the whole notion of a protective effect of moderate alcohol use can be consigned to the ash heap of unproven hypotheses'

Doubts about moderate alcohol use

By Richard Gilbert

This month I'll continue the report on my involvement in a conference in Bethesda, Maryland in October, organized by the United States National Institute on Drug Abuse and the US National Institute on Alcohol Abuse and Alcoholism.

The conference was titled, An examination of the distribution of consumption of dependence-producing drugs.

In doing this, I will describe some work by Alex Richman of Dalhousie University, Halifax, Nova Scotia that casts doubt on the validity of the accumulating evidence for the beneficial effects of moderate alcohol use.

I concluded last month's column by suggesting two ways in which Sully Ledermann's notions about alcohol consumption might be given new life. Dr Ledermann had argued in the 1950s that the amount of alcohol abuse in a population is related to the average alcohol consumption of the population. A conclusion from his work has been that *only* population-wide measures (such as price increases) can be effective in reducing alcohol use. I argued that little progress had been made toward justifying this conclusion. As a result, research in this area had become sterile.

One new avenue would be to apply Ledermann's notions to popular drugs other than alcohol, particularly nicotine and caffeine. I showed last month how such an application might provide useful insights into the dynamics of the patterns of consumption of popular drugs.

Another new avenue I suggested to the conference would be to apply Ledermann's formulation not simply to the reduction of alcohol use, but also in an attempt to achieve the optimal average level of alcohol use in a population.

Optimal alcohol use

The notion of optimal alcohol use arises when it is believed that using moderate amounts of alcohol is beneficial compared with using none at all or using more than moderate amounts. If the whole population could be induced to drink the amount that confers a benefit, then clearly the average consumption of the population would be at an optimal level.

Conversely, if all alcohol use were believed to confer a cost — as is all use of tobacco, at least from the point of view of individual health — then the optimal level of alcohol use would be zero consumption.

I reviewed some of the burgeoning evidence for the beneficial effects of alcohol use in my December 1983 column. I mentioned half-a-dozen recent studies that, in differing ways and in differing degrees, supported the notion that moderate alcohol use gives protection against coronary heart disease.

Of particular importance was a study by John Thornton and colleagues who found increases in high-density lipoprotein (HDL) cholesterol levels in volunteers who increased their alcohol use under controlled conditions. HDL cholesterol is recognized as an anti-atherogenic agent. This work, with other similar reports, appeared to give a mechanism for the apparent protection afforded by moderate alcohol use. Protection exists to the extent that the anti-atherogenic effect of the HDL cholesterol outweighs the direct damage done to the heart by higher concentrations of alcohol.

In a later column (**The Journal**, January), I argued that public health policy should involve attempting to order the pattern of alcohol consumption in a population so that the net medical benefit from alcohol would be the greatest. The net benefit would be found by subtracting the mortality caused by excessive alcohol use from the deaths prevented by moderate use.

According to Ledermann, the distribution of alcohol consumption is always log-normal, and alterable only by changing the average alcohol consumption of the population. To achieve optimal alcohol use, the distribution would have to be such as to achieve the next largest saving of life.

Some very rough calculations I did for a column in the spring of 1980 indicated that with the current, average alcohol consumption of close to two drinks per day in Ontario there was a net saving of 430 lives a year as a result of alcohol use (**The Journal**, May 1980). This average is higher than the optimal level, which I calculated to be close to one drink a day. At the optimal level, the net saving would be in the order of 900 lives a year.

Proper estimation of the optimal alcohol use of a population was the second suggestion I made to the Bethesda conference for giving the Ledermann formulation new life.

HDL cholesterol subfractions

During this year some problems have emerged with the notion that moderate alcohol use is beneficial. A minor problem was posed by the appearance in March of a report in the *New England Journal of Medicine* by Dr W.L. Haskell and six other authors of a study of how amounts of various subfractions of HDL cholesterol vary with alcohol consumption. Moderate drinkers were induced to abstain from alcohol for six weeks. Overall, HDL cholesterol levels declined compared with those in control subjects who did not abstain, as might be expected from earlier work. However, the decline was attributable to a lowering of the levels of HDL3, the heavier subfraction of HDL cholesterol *not* associated with anti-atherogenesis. Levels of HDL2, previously thought to be the anti-atherogenic subfraction, remained unchanged during abstention.

The authors concluded (i) that the association of alcohol with heart disease is not mediated by increases in plasma HDL2 levels; (ii) that HDL3 may have some relation to heart disease; and (iii) the association of alcohol with heart disease may be mediated through some other mechanism.

The British researcher Dr D.P. St George, writing in the Canadian journal *Medical Hypotheses*, had suggested in November 1983 that moderate alcohol consumption may reduce risk of coronary heart disease by depressing arousal of the central nervous system and consequently depressing unspecified neuroendocrine mechanisms. No evidence was adduced to support this contention, but it indicates the possibility of alternative mechanisms for a possible protective effect of moderate alcohol use.

The strongest attack on the validity of the notion that moderate use may give protection against heart disease has come from Dr Richman of Dalhousie University. His work has not yet been published, although it appeared as a "poster" at the annual meeting of the American Association for the Advancement of Science in New York in May this year.

Dr Richman re-examined relevant parts of the 1978 Canadian Health Survey, in which the health of a probability sample of 17,249 Canadians was determined using questionnaire and clinical methods. The questionnaire included items concerning alcohol consumption. He found that, on average, moderate drinkers had better health than both abstainers and heavy drinkers, with abstaining, former heavy drinkers having the worst health. However, just about all of the difference in health between abstainers and moderate drinkers could be accounted for in terms of age, sex, income, and other characteristics.

Studies of mortality from heart disease in relation to alcohol consumption have been of a correlational nature — one variable changes with another, but it is not clear which is the cause and which is the effect. The assumption to date has been that in the relation between alcohol consumption and mortality, alcohol consumption has been the cause and mortality has been the effect.

Healthy drinkers

Dr Richman's work points us in the other direction. His finding that the poorer health of abstainers can be almost wholly accounted for in terms of factors other than alcohol use leads to the conclusion that it is not their alcohol use that gives moderate alcohol users good health, but rather it is their good health that permits them to drink alcohol. Dr Richman hastened to add that there was no evidence that moderate alcohol use actually caused harm.

If Dr Richman is right — and it must be remembered that his analysis is essentially as correlational as the previous work — then the whole notion of a protective effect of moderate alcohol use can be consigned to the ash heap of unproven hypotheses. This particular hypothesis has perhaps been sustained by wishful thinking — by me and by others.

If Dr Richman is right, there is no need to pursue the application of Ledermann's arguments to estimating the optimal alcohol use for a population. My suggestion of a new application for Ledermann's work should be put on hold while further evidence comes forward on this most interesting question as to the relation between moderate alcohol consumption and the incidence of coronary heart disease.

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Cigarettes hold a key position in effective anti-drug planning

On Canada's drug scene, the year 1984 will be remembered for a striking change in our perception of, and approach to, the costly problem of drug abuse. For at least cigarette addiction has, against monumental social inertia, recognizeably come into its own as this nation's leading addictive drug dependency. Certainly, in terms of the intensive pain, grief, and suffering it causes, all of our other drug problems, even when taken together, fall well back into second place.

Today, chronic, compulsive smoke inhalation is clearly seen to be the prior, the trigger, the companion, and the dominant addiction in Canadian society. Moreover, today we are aware that "cigarette roulette" is a game with an abnormally high incidence of adverse risks for the players, risks which non-players are increasingly reluctant to share.

In all present and future planning, then, of effective strategies for reducing drug abuse here, in the United States, and abroad, cigarette smoking now holds the key position. Not only does it open the door to other drug dependencies, but it also lowers the tobacco user's resistance threshold making it that much easier, if so disposed, to step over and through.

At this moment, more than seven million Canadians simply cannot face the day, or function in it, without inhaling smoke repeatedly. Normally, they would all be horrified at the thought of having to do so. No up-to-date program aimed at dealing effectively with alcohol and other drug concerns can therefore afford to ignore cigarette (nicotine) addiction and its primary impact on the health and wealth of this nation. Indeed, to do so, from this year onward, would be to operate conspicuously under false pretences and without credibility.

It will not be easy, for example, on behalf of our school children, to convince parents and teachers, especially those who smoke, that cigarette use is in a class with heroin, cocaine, and "speed" (methamphetamine) use. Nonetheless, for many of those who have tried to break its stranglehold, cigarette smoke is, by any measure, well known to be the hardest drug of all.

What, then, can be done to utilize our present understanding of tobacco use, to reduce sharply drug abuse, and the need for it, at home and abroad?

Since tobacco is today the acknowledged king-pin of the drug abuse scene, it makes eminent sense to limit drastically both its availability and accessibility. There is, for example, already a good federal law prohibiting the sale of tobacco in any form to children less than 16 years of age. Strict enforcement of this law would, of course, cause quite a stir, but, in my view, would be surprisingly welcomed, particularly by parents who are truly against their children's use of harmful drugs.

There are, of course, many other ways to shrink the tobacco problem and, concurrently, through the "domino effect," to shrink the tobacco-linked problems caused by alcohol and other drugs. It is up to us all to cultivate in our children the determination to turn thumbs down on cigarette smoking and, by doing so, to avoid wider involvement in the debilitating drug scene.

George F. Lewis
Associate Professor of Anatomy
McMaster University
Hamilton

Families feature fine contribution

Please accept our congratulations on a very fine contribution on families and alcohol in your October special section (Families and alcohol — A legacy of love and pain).

We would like any further information you might have on this topic.

Thank you very much for your assistance.

Andrew L. Homer, PhD
Coordinator, Support Services
State of Missouri
Department of Mental Health
Jefferson City, Missouri

Editor's note: A bibliography is on its way.

'Sacred cow' of drug laws needs closer scrutiny

The Journal does a good job in collecting news items and reporting events. However, it tends to dwell on the sensational, that is, the use of prescription drugs for recreational purposes by 3/10ths of one percent of the population, and totally ignore the health promoting and life saving aspects of such drugs when consumed by more than 99% of the rest of the population when they are patients.

When will the publication build up enough courage to question the sacred cow of drug laws? Will the Ontario legislature's call for use of heroin for medical treatment arouse your concern?

Drug laws:

- Hurt most people who are patients, for they suffer from inadequate pain relief.
- Cannot be effectively enforced.
- Represent prohibition, and prohibition has always failed.
- Inspire incredible, nonsense-pronouncements from drug bureau officials.

A front page article in the September issue of **The Journal** (Addicts trying new tricks to get R_x drugs) tells us that pharmacy break-ins and robberies have decreased because drug users are managing to fill some of their needs by paid-for prescriptions.

The article directly below, Police cracking down on drug scams/Abusers pose as CA patients, sounds brilliant, until you consider that, if effective, such tactics will guarantee an increase in pharmacy break-ins, in which no payment is made for the drugs taken.

Such self-defeating stupidity, which is carried on endlessly by people in positions of authority, and is putting the country another $4 billion a year deeper in debt, should be exposed.

Robert L. Foster
Burnaby, British Columbia

INDEX OF HEADLINES FOR 1984
— pull-out section —

The Journal

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PULL OUT

INDEX FOR 1984

January

February

March

The Journal

INDEX FOR 1984

April

Alcohol, Drugs, and the Doctor

— A symposium of opinion —

May

June

The Journal
INDEX FOR 1984

July

August

September

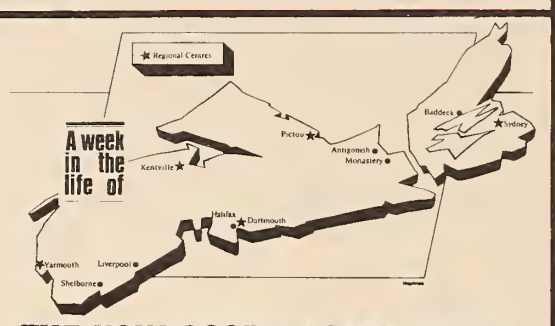
The Journal

INDEX FOR 1984

October

Families and alcohol: A legacy of love and pain

November



THE NOVA SCOTIA COMMISSION ON DRUG DEPENDENCY

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NEWS

Patients may resist attempts to replace drugs

MDs warned of sleep-aid dangers for aged

By Betty Lou Lee

MONTREAL — Elderly people who habitually use barbiturate hypnotics for sleep may strongly resist any effort by their doctor to withdraw them, but the drugs are particularly hazardous to this age group.

Psychiatrist Jonathan Fleming, director of the sleep disorders clinic at Shaughnessy Hospital, Vancouver, says there are five disadvantages to these drugs, and he has worked out a withdrawal program.

Toxicity is the major disadvantage: two grams of a short-acting barbiturate can be lethal, and depression is the most common psychiatric disorder in the elderly.

"Suicidal behavior is frequently associated with this disorder. Unlike younger patients, the aged usually succeed on their first attempt," he told the annual meeting here of the Royal College of Physicians and Surgeons of Canada.

The drugs also depress respiration and decrease the natural arousal response to sleep apnea, which is common after 65 years. The drugs interfere with liver enzyme systems, altering the metabolism of vitamins K and D, and increase the rate of metabolism of drugs like tricyclic anti-depressants and coumarin anticoagulants.

There is a risk of physical and psychological dependence. Barbiturate hypnotics lose their efficacy over time, the quantity and quality of sleep worsens, and patients tend to increase the dose.

Their long retention time in the body results in a hang-over effect that can result in traffic and home accidents.

Dr Fleming noted that such prescriptions for the elderly have steadily declined since introduction of the benzodiazepines in the late 1960s, but many such patients resist any attempt to discontinue or replace the drugs.

"Older patients want to obtain the same sleep efficiency they enjoyed in younger years and are unaware that, with increasing years, the quality and quantity of sleep naturally declines."

Some get withdrawal reactions when they don't take the hypnotics, such as a lengthening of the time it takes to get to sleep, more awakenings during the night, and bizarre and frightening dreams.

Dr Fleming suggested that sleep history, with retiring and rising times, awakenings, sleep onset times, and time spent napping should be recorded. Patients should complete a sleep diary for a week.

Explanations about normal sleep patterns in the elderly and the disadvantage of barbiturates should be given.

For uncomplicated withdrawals, when a patient is taking medium doses of barbiturates, he reduced the dose gradually — by less than 10% per week — for those patients who are well motivated. For those who are less motivated, he substitutes diazepam for the barbiturates, later reducing the diazepam gradually.

He warns that sleep will be fragmented for up to two weeks, and stresses the importance of exercise, regular bed times, and avoiding naps.

Those who are psychologically dependent are asked to take part in an experiment in which their hypnotic is taken in a suspension of methyl-cellulose. Without their knowledge, the drug concentration is gradually decreased to zero over seven weeks, even though they take the same 5 millilitres of liquid for each dose.

Complicated withdrawals, which can occur when the patient is abusing the drug or combining it with alcohol or other sedative/hypnotics, require a short hospital admission, Dr Fleming said.

"As prevention is the better part of cure, it is important to remember that currently there are no indications for prescribing barbiturate hypnotics; the benzodiazepines are the drugs of choice for treating geriatric insomnia and should be used for the shortest time possible, and for no longer than six weeks of continuous use.

"Often we renew barbiturate prescriptions without thinking, or, after having thought, decide that it is easier for everyone to continue as before. It may be easier, but it is not safer."

Older patients: the quality and quantity of sleep declines

Lack of patient compliance a major problem in elderly

By Tim Padmore

VANCOUVER — Drug abuse is common among the elderly and the highest risk of all is run by the patient who:

- is more than 85 years — one of the "old old;"
- is female;
- takes a large number of drugs, including over-the-counter drugs;
- suffers from a number of chronic conditions, especially malnutrition;
- has impaired hearing and vision;
- is physically handicapped;
- has poor social support; and,
- has recently had a lifestyle change.

That portrait was painted for doctors attending the 26th annual scientific assembly here of the College of Family Physicians of Canada by John Keddy, medical director of the DVA unit of the Dr Everett Chalmers Hospital, Fredericton, New Brunswick.

Lack of patient compliance is a major problem with the elderly and occurs up to half the time, said Dr Keddy, but the responsibility often lies with the physician.

For example, the elderly often forget oral instructions. So it is up to the doctor to make sure all relevant information is written.

"One should never write 'as directed' on a prescription," Dr Keddy said.

Prescriptions also have to be accurate and appropriate, he said, and that involves the physician's understanding changes that take place with age:

- kidney and liver function are impaired, so drugs are broken down and excreted much more slowly;
- protein binding is reduced, so there is more free drug in the bloodstream; on the other hand, absorption from the stomach is often slower;
- increased body fat can increase accumulation of lipid-soluble drugs like diazepam and phenobarbitol;
- binding sites are probably more susceptible, and the blood-brain barrier more permeable, leading to increased toxic effects of many drugs;
- congestive heart failure can reduce absorption, so the physician who successfully controls the heart disease may find his patient poisoned by a dose of another drug that he or she had previously tolerated.

The elderly often need more sleep than the young, but also may nap during the day and thus have broken sleep at night; this knowledge should temper the physician's response to requests for sleeping medication, especially drugs that seem aimed more at benefiting family or hospital staff than the patient.

Before prescribing anti-depressants, Dr Keddy suggested, physicians should remember that depression is often related to a loss of some kind.

"Depression can often be treated with understanding and help in alleviating obvious underlying problems."

Dr Keddy told **The Journal** the toughest psychological problem is dealing with overuse of tranquillizers and pain medication.

"You have to try to extract from the patient what they think they are getting from the drug, then suggest alternatives and point out the long-term effects.

"It takes a lot of time. It always takes more than one visit."

Liquor sales slump tied to economy

VICTORIA — Consumption of wine and spirits in British Columbia dropped 5% last year.

The provincial liquor distribution branch (LDB) says sales totalled 64.5 million litres in the year ending June 30, compared to 67.8 million litres in the comparable period a year earlier.

LDB spokesperson Pam Vest told **The Journal** the decline can be attributed to a combination of economic hard times and "people becoming more conscious of what they are drinking." Many are opting for low alcohol content beverages.

The most dramatic trend is a switch away from spirits. Domestic spirit consumption dropped 10% to 19 million litres, and is down by one-quarter from 1981.

Imported beer sales were up dramatically, but still constitute only a small fraction of total beer sales.

Aggregate figures for beer consumption are not available, but Ms Vest said there has been little change in beer's market share.

Amethyst recovery rates are 'better than average'

OTTAWA — Clients who completed the Amethyst Women's Addiction Centre program here did better than average in reducing their drinking, says the Centre's report to Health and Welfare Canada.

A year after completing the four-week program at Canada's first women-only treatment centre, 46% of the clients were abstinent. Another 25% had improved, while 29% continued to drink heavily.

One reason for the success, the report states, is that the clients receive assertiveness training in a treatment environment that emphasizes equality and mutual respect (**The Journal**, Aug).

The report outlines the results of programs at the centre and provides "a persuasive argument for planning future services for women." Amethyst receives much of its funding from the federal government.

Since Amethyst began in 1979, 415 women have been assessed and 227 entered programs. Amethyst services include day programs, community outreach, one-to-one counselling, and follow-up.

When Amethyst first opened, only clients whose major problem was alcohol were admitted to the day program. However, as staff gained experience, women with other drug problems were also accepted.

The report notes that integrating street drug addicts with alcoholics in treatment groups has presented problems. Street drug users must often break the law to support their habit, a problem that alcoholics and prescription drug users don't have.

"Consequently, when the (treatment) group begins to explore lifestyles and how to cope, the drug addict, who is always a minority in the group, feels left out," the report says.

A couples group, a detox centre, and improved education programs are new projects under consideration. One of Amethyst's goals is to raise 25% of its yearly budget from the private sector to meet these financial needs.

NEWS

Sombre DWI message counters alcohol ads

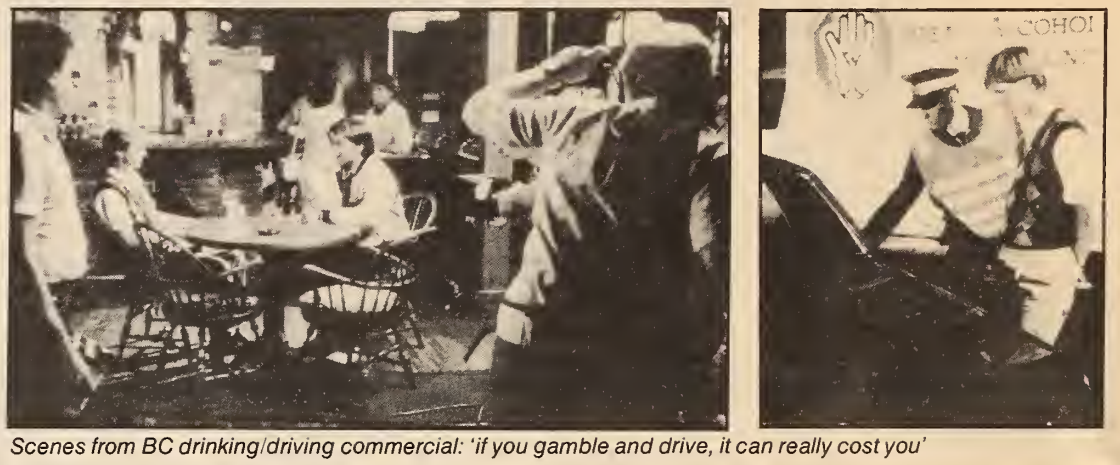
Scene: A congenial pub. A man sets down an empty glass, drops a quarter on the table, then 60 cents more, then a few crumpled bills . . . then picks up his car keys.

A voice says: "If you've had too much to drink and need to get home, it's going to cost you . . . a quarter to phone a friend . . . a little more for the bus . . . still more to take a cab . . . but if you gamble and drive while impaired, it can really cost you . . ."

The scene dissolves to a flashing red light . . . the man blowing into a breath-testing machine . . . being handcuffed and led away.

Voice: ". . . your licence, six months in jail, a $2,000 fine . . . if you have an accident, your insurance company will make you pay back every penny . . ."

The final scene is back in the pub, where the man drops his keys back on the table, and picks up the quarter, while the voice-over concludes: "But . . . it's up to you."



Scenes from BC drinking/driving commercial: 'if you gamble and drive, it can really cost you'

VANCOUVER — That sombre message will be replayed for British Columbia citizens dozens of times in the next year.

It is one of three new commercials produced by the BC attorney-general's ministry for use by the province's television stations as a counterbalance to commercials promoting the use of alcohol products. The commercials went on air in September.

They reflect an effort by the ministry to do something different from the standard emotional appeal — the liquid-eyed, fatherless children and bloodied wrecks.

Two of the new commercials were based on a survey of more than 600 BC residents.

"One of the things we found," said G. William Mercer, PhD, research director for police services, "was that not one person could accurately cite the penalties for a first (impaired-driving) offence."

People typically cited a relatively small fine, and no one mentioned the possibility of a jail term.

"For the law to have a deterrent effect, people have to know what the law is," Dr Mercer told **The Journal**.

Two of the three commercials produced this year deal with the legal penalties facing drinking drivers.

A third is based on another research finding: In BC more than half the people killed by drinking drivers are passengers.

"Fatalities could be reduced by more than half if people stopped riding with drinking drivers," said Dr Mercer.

To encourage them, the television camera records details of the interior of a wrecked car, lingering on the shadow cast on the passenger seat by the shattered windscreen. The voice-over intones: "Each year in BC thousands suffer, hundreds die . . . here . . . in the passenger seat of a drinking driver's car."

Representing about one-quarter of the government's CounterAttack program against drinking and driving, the commercials cost about $50,000 each.

Tim Padmore reports

Medics want more prime time air

Broadcasters honor ad accord

VANCOUVER — British Columbia broadcasters have generally honored a bargain that gave them the privilege of airing commercials for beer and wine.

The ads started two years ago, with the understanding that the broadcasters would also air, free-of-charge, educational material aimed at preventing alcohol abuse.

A quota of 15% of the air time devoted to pro-alcohol advertising was established, and a reporting system set up to monitor performance.

The ministry of consumer and corporate affairs, which regulates liquor sales and advertising in the province, says the broadcasters have usually met the quota and lately have been exceeding it.

Earlier this year, the government claim got some independent confirmation when the citizen group, Mothers Against Drunk Driving, in cooperation with the Alcohol Dependency Committee of the BC Medical Association (BCMA), conducted a week-long, 16-hour-a-day watch on one local station.

The results: 79 pro-alcohol ads for a total of 2,196 seconds, and 12 educational ads for a total of 305 seconds.

The air time ratio was 14% and the frequency ratio 15%.

George Kovacs, MD, chairman of the BCMA committee and an assistant professor in the University of BC department of psychiatry, said the group had, nevertheless, two criticisms: a relative scarcity of public service announcements during prime evening time and overuse of two commercials produced last year by the attorney-general's ministry.

Allan Gould, general manager of the provincial liquor control and licensing branch, said that broadcasters file monthly reports of the commercials, pro and con, that they have aired.

Quotas for individual stations are calculated from the total pro-alcohol ads recorded in the previous year.

Perhaps because of the slowing economy, he said, the educational air time has averaged above 15% recently, especially on radio.

Dr Kovacs told **The Journal**: "We cannot deny, there is quite an effort (to comply) on behalf of the (broadcasting) industry." He added that new educational commercials that went on the air in September partially answer his complaint about overuse.

Threat of injury and prosecution deters South African drunk drivers

Johannesburg: a high incidence of alcohol-related accidents

PRETORIA — Two South African studies have shown that anti-drunk driving campaigns can have some impact on behavior.

The studies investigated attitudes toward, and knowledge of, drinking and driving before and after a holiday season campaign.

Lee Rocha-Silva, of the Human Sciences Research Council here which conducted the attitudes research, said the first study "was directed at ascertaining the attitudes to drinking and driving of Blacks and Whites in a major metropolitan area including Pretoria and Johannesburg, and in the Transvaal, the most northern province of South Africa.

The study was undertaken in 1981, Ms Rocha-Silva said, in response to a high incidence of alcohol-related road accidents and the assumption that tolerant attitudes and lack of, or distorted, knowledge about the impairing effect of alcohol on driving performance contributed to this.

Those surveyed said they:

- disapproved of drinking and driving, and/or drunk pedestrians, and most were in favor of legislation directed at curbing this behavior;
- knew that drinking and driving was punishable by law; and,
- were aware of the possible detrimental effects of alcohol on the body.

Approximately 40% of Whites and 60% of Blacks believed the current (1981) legislation and its application were not strict enough. However, they often underestimated the existing maximum penalties for drinking and driving.

Following a November 1981 to January 1982 National Road Safety Council (NRSC) campaign against drinking and driving, a second survey was taken in 1982 of White adults in the Pretoria and Witwatersrand area. The survey found that the majority of respondents were reached by the NRSC campaign, Ms Rocha-Silva reports.

For example, the campaign penetrated the everyday conversation of about 30% of the men and almost 25% of the women interviewed. A subject particularly discussed was the possibility of road accidents and prosecution following drinking and driving.

The campaign reached the respondents mainly through television and, to a lesser extent through newspapers, periodicals, and radio. Advertisements with the most impact in terms of recall appeared to be:

- one which said: "Drinking and driving may give you a hangover for life;"
- one illustrating detention and fining in a South African police station with the words: "It is criminal to drink and drive."

Regardless of the communication medium used, the possibility of road accidents and prosecution made the biggest impression, the survey found.

Virtually all those interviewed believed the campaign had been successful, and approximately 70% believed alcohol-related road accidents had decreased. Most also thought campaigns of this nature should be repeated, and not only during the Christmas season. Many (51.4% of the men and 58.1% of the women) believed the campaign had succeeded in improving the image of the police. About 50% of the men and 60% of the women thought legislation on drinking and driving should be made more severe and should be more forcibly implemented.

About 40% of the men and 30% of the women who admitted drinking and driving said the campaign motivated them to change their behavior and said fear of accidents and prosecution were the main reasons.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000 ext 7384.

Chug

Number: 623.
Subject heading: Alcohol/alcoholism overview.

Details: two 10 min, cartoon filmstrips, tape, color.

Synopsis: The filmstrips tell a story about Chug, a 500-kilogram character with wings, the tail of an alligator, the feet of an elephant, and all put together with zippers. Chug lives under a bridge and demands payment from those using the bridge. Two children find Chug in a terrible state because he has consumed an enormous amount of alcohol given to him by a previous user of the bridge. The children explain to Chug the effects of alcohol and why he is feeling so badly. Sometime later, Chug goes to a party where he again drinks too much. This time he goes to a doctor to try to understand why he feels so terrible. The doctor explains to Chug what has happened.

General evaluation: Very good (5.4). These well-drawn, humorous filmstrips were judged good teaching aids with a clear message.

Recommended use: With a resource person, these cartoons would benefit audiences aged 8 to 14 years.

Drugs: Don't Be Fooled

Number: 624.
Subject heading: Drugs — pharmacology.
Details: 16 min, color.
Synopsis: In a simulated chemistry class, the teacher asks the students about all the classifications of drugs and their effects. The students tell, in great detail, what drugs can do. They also talk about misinformation that many people have, such as "everybody drinks." Young people are shown in different situations portraying how misinformation is used. The class is told to learn to recognize misinformation and to remember that all drugs can be dangerous.
General evaluation: Poor to very poor (1.7). Although much of the information was acceptable, and the scenes outside the classroom could be used as discussion starters, the students were obviously reading their responses, and the classroom setting seemed so contrived, that the film lost credibility.
Recommended use: With a resource person, this film could be used with 12 to 15 year olds.

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NEWS AND DEPARTMENT

Survey queries teen drug use, sex experience

By Betty Lou Lee

MONTREAL — There is sexual equality among Ottawa teenagers in their use of alcohol and other drugs, but girls are twice as likely as boys to be cigarette smokers.

A survey of 730 Ottawa students aged 12 to 20 shows that 49% use alcohol "regularly, or once in a while," and 15% use "recreational drugs" on the same basis, with no significant difference between the genders. (The term "recreational drugs" was used in the survey, with no further explanation.)

But, 36% of girls and only 16% of boys use tobacco regularly or once in a while.

William Feldman, MD, professor of pediatrics at the University of Ottawa, and head of ambulatory services at the Children's Hospital of Eastern Ontario, reported the results at the annual meeting here of the Royal College of Physicians and Surgeons of Canada.

One finding in the survey was that 25% of the girls had had sexual intercourse, but only 18% of the boys.

Dr Feldman speculated that two factors in the difference of sexual experience could be the girls were involved with older males, or the teenaged boys had multiple partners.

The students answered questionnaires covering a wide range of health concerns and health-related behavior.

Acne was the number one concern for 47% of both boys and girls.

One-third of all students reported family problems, but there were significantly more girls in this group. Dr Feldman suggested "more of them are doing things that lead to hassles with their parents."

In the 12- to 13-years age group, 9% were smoking, 2% were using recreational drugs other than alcohol, 14% had used alcohol, and 3% had had sexual intercourse.

By 14 and 15 years of age, 21% were smoking, 37% had used alcohol, 9% had used other drugs, and 11% were sexually experienced.

At 18 to 19 years, 36% smoked, 78% had used alcohol, 27% had used other drugs, and 47% had had intercourse.

Of the 4% who thought they had problems with alcohol or other drugs, 34% had talked to a doctor about it, and 63% said they would like to consult a physician. More than half of the total sample said they would feel comfortable talking to a doctor about such problems.

"Although the literature says teenagers don't go to doctors, 85% had seen one in the last 12 months," Dr Feldman noted.

One-third of the girls who were sexually active had spoken to a doctor about birth control.

New Books

by RON HALL

Alcohol Dependence Scale (ADS)

. . . by Harvey A. Skinner, and John L. Horn

The Alcohol Dependence Scale was developed to provide a brief but psychometrically sound measure of the alcohol dependence syndrome. The aims of the manual are to review important developments in the alcoholism literature regarding the concept of alcohol dependence; to describe the reliability and validity of the ADS based on a major evaluation study; and to provide instructions for the administration, scoring, and interpretation of the ADS. The 25-item ADS may be administered in either a questionnaire or interview format, and generally should take less than 10 minutes to complete. The questionnaire version is usually preferred because it permits the efficient assessment of large samples in a brief time and with a minimum expense.

[Addiction Research Foundation, Marketing Services, Dept JR, 33 Russell St, Toronto, ON M5S 2S1, 1984. $15 (specimen set of 25 questionnaires and 1 user's guide), $14.25 (user's guide), $6.25 (package of 25 questionnaires). ISBN 0-88868-091-0]

Glue Sniffing and Volatile Substance Abuse

. . . by Denis O'Connor

This book describes the findings from three years of clinical experience and research with over 500 school children and adolescents involved in the inhalation of poisonous fumes from a number of products in everyday domestic and commercial use. The studies reported grew out of a series of chance encounters that were unplanned and unsolicited. Attention is directed towards the emotional experiences which sniffers have in common and which generate the stresses that lead to intoxication practices. The author aims to show that the objective findings emerging from studies of solvent abuses in the population are made credible only when they are broken down in terms of the subjective state of the individual abuser. It is believed that the management and treatment of behavior problems will only truly be effective when caring approaches are aimed at the subject — the person — rather than the symptomatic behavior.

(Gower Publishing Company, Old Post Rd, Brookfield, VT 05036, 1984. 116 p. $29.95. ISBN 0-566-00641-3)

Other books

Earl Mindell's Pill Bible — Mindell, Earl L. 1984. Medicines; meals and medicine; illicit and abused drugs; special problems for senior citizens; drugs and sex; alcohol and other drugs; smoking and drugs; glossary; bibliography; index. Bantam Books, 666 5th Ave, New York, NY 10103. $8.95. ISBN 0-553-34064-6.

UK drug group shifts quarters

LONDON — The Institute for the Study of Drug Dependence (ISDD), Britain's chief resource on drug dependence and misuse, which provides information worldwide to professionals, academics, and the public, has changed its address.

ISDD can now be reached at 1-4 Hatton Place, Hatton Garden, London ECIN 8ND, telephone: 01-430-1991/2/3.

DEPARTMENT

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Medical Writing for Publication — Dec 6, 1984 and Feb 14, 1985, Toronto, Ontario. Information: Professional Services, 205 Humber College Blvd, Rexdale, ON M9W 5L7.

Group Therapy Course — Jan 14-18, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation (ARF), 8 May St, Toronto, ON M4W 2Y1.

Symposium 85: Focus on the Family — Jan 21-25, 1985, Toronto, Ontario. Information: Cynthia Rasky, Metatron, 53 Lisa Cres, Thornhill, ON L4J 2N2.

Chemical Abuse and Your Employee — Jan 23, 1985, Toronto, Ontario. Information: Yvonne Johns, department head, Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Ontario Psychiatric Association Annual Meeting — Jan 24-26, 1985, Toronto, Ontario. Information: Frank E. Cashman, Program Committee Chairman, or Jean Reed, Executive Secretary of the Ontario Psychiatric Association, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Health Promotion Workshop —Feb 13-15, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

38th Annual Convention of the Ontario Psychological Association — Feb 14-16, 1985, Ottawa, Ontario. Information: Harvey Brooker, Convenor, OPA 85, 1407 Yonge St, Ste 401, Toronto, ON M4T 1Y7.

An Employer Needs to Know: Intervention — Feb 20-22, 1985, Toronto, Ontario. Information: Yvonne Johns, department head, Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

6th Annual Conference of the Canadian Association of Addiction Counsellors — Cross-Addictions — Feb 23, 1985, Toronto, Ontario. Information: Kathryn Irwin, 3253 Bathurst St, #B3, Toronto, ON M6A 2B3.

Relaxation and Stress Management Course — March 7-8, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Behavioral Interventions Course — March 27-29, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Alcohol and the Family Workshop: Community Program Approaches — May 6-7, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Marital and Family Therapy Course — May 8-10, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

National Conference on Autism — May 15-17, 1985, Winnipeg, Manitoba. Information: Manitoba Society for Autistic Children, 649 Bardal Bay, Winnipeg, MB R2G 0J1.

Parent Resources Institute for Drug Education (PRIDE-CANADA INC) 1st Annual National Conference — May 30-June 1, 1985, Saskatoon, Saskatchewan. Information: Ruth Kell, Convenor, PRIDE-CANADA, Ste 111, Thorvaldson Bldg, College of Pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

Medic Canada 85 — June 3-5, 1985, Toronto, Ontario. Information: Medic Expositions of Canada Inc, 67 Mowat Ave, Ste 242, Toronto, ON M6K 3E3.

Alcohol, Other Drugs and the Law Course — June 5-7, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Advanced Clinical Social Work Certificate Program — June 17-28, 1985, Toronto, Ontario. Information: Allen Cutcher, School of Continuing Studies, University of Toronto, 158 St George St, Toronto, ON M5S 2V8.

Summer School for Addiction Studies — July 15-26, 1985, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-10, 1985, Calgary, Alberta. Information: Jan Skirrow, Chairman, 34th ICAA Congress, AADAC, 6th fl, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

United States

Affirmations for Success with Chemically Dependent Families — Dec 5, St Paul, Minnesota. Information: Children Are People, Inc, 1599 Selby Ave, St Paul, MN 55104.

Hope for the Children, Support Group Training — Dec 5-7, Minneapolis, Minnesota. Information: Children Are People, Inc, 1599 Selby Ave, St Paul, MN 55104.

Cultural Aspects of Alcoholism — Dec 6-8, Beaumont, Texas. Information: Bill Rosemon, Texas Black Alcoholism Council, PO Box 8066, Houston, TX 77288.

Healing Adult Children of Alcoholics — Laughter, Creativity and Play — Dec 7-9, Marine-on-the-St Croix, Minnesota. Information: Children Are People, Inc, 1599 Selby Ave, St Paul, MN 55104.

Exempt Now — Included Later? The DRG Issue and Alcoholism/Drug Diagnoses — Dec 9-11, Washington, DC. Information: Fairlane Health Services Corporation, 1 Parklane Blvd, Ste 1002 W, Dearborne, Michigan 48126.

Family Recovery from Alcoholism and Drug Dependence — Dec 10-14, Minneapolis, Minnesota. Information: Seminar Coordinator, Johnson Institute, 510 1st Ave N, Minneapolis, MN 55403.

Assessing Adolescents with Alcohol and Drug Problems — Jan 14-16, 1985, Ft Lauderdale, Florida, Jan 21-23, Houston, Texas, Feb 14-16, Portland, Oregon, Feb 18-20, Honolulu, Hawaii. Information: Joanne Terry, Johnson Institute, 510 1st Ave N, Minneapolis, Minnesota 55403-1607.

11th Annual Symposium, Alcoholism — The Search for the Sources — Jan 16-18, 1985, Raleigh, North Carolina. Information: Alcoholism Research Authority, c/o Wing B Medical School Building 207-H, University of North Carolina, Chapel Hill, NC 27514.

The Growing Concerns of the Growing Child: A Fresh Look — Jan 23, 1985, Garden City, New York. Information: Ann Boehme, Continuing Education Coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042.

Perspectives on Alcohol, Drugs, and the Family — Jan 24-26, 1985, Albuquerque, New Mexico. Information: Joanne Terry, Johnson Institute, 510 1st Ave N, Minneapolis, Minnesota 55403-1607.

Adult Child of the Alcoholic — Jan 26, 1985, Detroit, Michigan. Information: Fairlane Health Services Corporation, 1 Parklane Blvd, Ste 1002 W, Dearborn, Michigan 48126.

Adolescents, Alcohol and Drugs — Jan 28-29, 1985, Denver, Colorado, Feb 14-15, Phoenix, Arizona, Feb 25-26, Austin, Texas. Information: Joanne Terry, Johnson Institute, 510 1st Ave N, Minneapolis, Minnesota 55403-1607.

Understanding and Working with Alcohol and Other Drug Related Issues in the Older Population — Feb 18-20, 1985, Miami, Florida. Information: Joanne Terry, Johnson Institute, 510 1st Ave N, Minneapolis, Minnesota 55403-1607.

Adult Children of Alcoholics Round-Up — Feb 22-24, 1985, Orlando, Florida. Information: The US Journal, 2119-A Hollywood Blvd, Hollywood, FL 33020.

1st Annual Convention on Children of Alcoholics — Feb 24-28, 1985, Orlando, Florida. Information: Conference Coordinator/Disney, The US Journal, 2119-A Hollywood Blvd, Hollywood, FL 33020.

8th Annual Alcoholism Symposium, Strategies and Objectives for Treatment Interventions — March 9, 1985, Boston, Massachusetts. Information: Douglas Jacobs, Director, Continuing Education division, The Cambridge Hospital, department of Psychiatry, 1493 Cambridge St, Cambridge, MA 02139.

NECAD — Northeastern Conference on Alcoholism and Drug Dependence — March 24-27, 1985, Newport, Rhode Island. Information: Edgehill-Newport Foundation, Beacon Hill Rd, Ste 106, Newport, RI 02840.

PRIDE's International Conference on Youth and Drugs — April 24-27, 1985, Atlanta, Georgia. Information: Parent Resources Institute on Drug Education, 100 Edgewood Ave, Ste 1216, Atlanta, GA 30303.

Central Region Conference of the Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA) — May 7-10, 1985, St Louis, Missouri. Information: Della Kinsolving, c/o St Elizabeth Medical Center, 2100 Madison Ave, Granite City, Illinois 62040.

16th Annual International Narcotic Research Conference — June 23-28, 1985, Seacrest, Massachusetts. Information: E. Leong Way, department of Pharmacology, University of California, San Francisco, California 94143.

Abroad

6th NGO's International Conference on Drug Dependence — Dec 10-14, Jakarta, Indonesia. Information: Sekretariat: Bersama, J1. Radio II/33 Kebayoran, Baru Jakarta 12130, Indonesia.

European Working Group on Drug Policy Oriented Research — Dec 13-14, Rotterdam, The Netherlands. Information: Wijnand Sengers, Erasmus University, PO Box 1738, 3000 Rotterdam, The Netherlands.

Scandinavian Study Tour on Drinking and Driving and Alcohol Policy — May 24-June 8, 1985, Oslo, Stockholm, Helsinki, Copenhagen. Information: Camilla Colantonio, department of conferences, Nolte Center, 315 Pillsbury Dr SE, University of Minnesota, Minneapolis, Minnesota 55455.

International Youth Forum on Alcohol and Drugs — July 9-12, 1985, Cardiff, United Kingdom. Information: Dr Myrddin Evans, Addiction Unit, South Glamorgan Health Authority, Whitchurch Hospital, Whitchurch, Cardiff, CF4 7XB, United Kingdom.

3rd International Conference on Alcohol and Drug Abuse — Aug 11-14, 1985, Lima, Peru. Information: L. Vasquez, MD, International Education, Peruvian College of Physicians, Wadsworth, Illinois 60083.

2nd National Drug Institute — Alcohol and Drug Use in a Changing Society — Aug 14-16, 1985, Darwin, Northern Territory, Australia. Information: Chairman, NDI Planning Committee, Drug and Alcohol Bureau, Northern Territory department of health, GPO Box 1701, Darwin NT 5794 Australia.

4th European Acupuncture and Alternative Medicine Symposium 2nd World Symposium on Moratherapy and Lasertherapy — Aug 30-Sept 1, 1985, Copenhagen, Denmark. Information: Secretary General, Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

12th International Conference on Health Education — Sept 1-6, 1985, Dublin, Ireland. Information: Dr H.D. Crawley, Director, Health Education Bureau, 34 Upper Mount St, Dublin, Ireland.

10th International Congress, World Confederation for Physical Therapy — May 10-22, 1987, Sydney, Australia. Information: The Secretariat, 10th International Congress of WCPT, Australian Physiotherapy Association, PO Box 225, St Leonards, NSW 2064, Australia.

Economic and political realities may impede Sri Lanka's severe anti-drug laws

Abarro (top left), Mendis: heroin an increasing problem in tea-producing Sri Lanka

COLOMBO — In May, Sri Lanka adopted one of the most severe anti-drug laws in the world; it's aimed at countering a dramatic, recent increase in addiction, particularly to heroin, and other problems associated with being a transit zone for international drug traffic.

Most experts in South East Asia are committed to the new law and to the needs for its severity.

Many also fear it may be doomed to very limited success by a range of political and economic realities and in the face of slim medical and counselling back-up.

The statute — Poisons, Opium and Dangerous Drugs (Amendment) Act, No 13 of 1984 — replaces the less stringent Ordinance of 1936. It decrees mandatory death or life imprisonment (minimum of 20 years) on conviction "by the High Court without a jury," for possessing, trafficking in, exporting, or importing two grams or more of heroin or cocaine, 3g or more of morphine, or 500g or more of opium.

Fines and terms of imprisonment for having, or dealing in, smaller amounts are also tough. For example, for "1 to 2g of heroin . . . fine not less than 100,000 rupees (approx Cdn $5,600) and not exceeding 500,000 rupees (approx Cdn $28,000) and imprisonment . . . for a period not less than seven years and not exceeding 20 years."

With the law came parallel legislation establishing the National Dangerous Drugs Control Board, with executive powers to direct police and customs. It has a financial allocation of some two million rupees (slightly less than Cdn $110,000), and a full-time acting chairman, the superintendent of police. The full-time appointment is a first.

There is now, also for the first time, agreement in principle to establish a Joint Task Force of police, customs, and intelligence services. It's a move local and foreign drug control advisers have been urging for years as crucial. So far it has not been implemented.

Critics suggest the relatively small financial allocation to the control board and failure to move on the task force shows lack of political will. Others say it's at least a beginning and must be seen in the context of the country, the area, and the tremendous speed with which drug problems have become critical there.

Attorney Pio Abarro is one of these.

Atty Abarro is founder and director of the drug advisory program of the Colombo Plan, an inter-governmental organization of 27 countries (six developed, including Canada) dedicated to cooperative socio-economic development in Asia and the Pacific region (**The Journal**, July 1983).

At an October meeting in Albany, New York, of the International Narcotics Enforcement Officers Association, Atty Abarro set Sri Lanka in regional context.

The region, he explained, encompasses the three largest opium/opiate producing areas in the world, for both licit and illicit purposes: the Golden Triangle of Thailand, Burma, and Laos; the Golden Crescent of Pakistan, Iran, and Afghanistan; and India, which produces licit opium for world medical needs. Last year, however, India reported to the United Nations Commission on Narcotic Drugs, meeting in Vienna, that it had a stockpile of about 2,000 tonnes of surplus opium.

In many countries in the region marijuana also grows wild and has done for centuries.

In Sri Lanka, Atty Abarro said, "heroin is new . . . . Nobody knows or pretends to know how it came. When I came to Sri Lanka 11 years ago, there was no heroin. The development of air transport, communications, trade, and tourism are contributory factors to its coming.

"We knew heroin had come when some overdose deaths of foreign tourists were reported to the authorities. It started about 1980. In the same year the Colombo Plan sponsored a short study/survey of the drug problem . . . with the police and the Narcotics Advisory Board. The consultant's report indicated a growing heroin-using population estimated at less than 50. From that to an estimated 2,000 to 3,000 after four years is about a 40-times increase."

In an interview with **The Journal** in Sri Lanka, Atty Abarro termed the new law a "political awakening."

While they occasionally appear sceptical about the law's potential for implementation, other experts also support it.

Senior Deputy Inspector General of Police Suntharalingam says: "We must have a powerful deterrent law — on which we can build."

The deputy leader of the parliamentary opposition, Laxman Jayakody, who, as a minister in a previous government, virtually prepared the ground for this legislation, says: "We are for it. This is not a government/opposition problem but a national menace as far as we are concerned."

And Atty Abarro added: "Of course we hope that it has not been overdone. Effective enforcement becomes the key issue now."

Enforcement, however, is essentially in the hands of the Police Narcotics Bureau, a force of 24 officers under a superintendent. This number to cover an island area of some 65,000 square kilometres and approximately 15 million people, some 30% in the "most vulnerable" 15- to 30-year-old age bracket.

In their defence, it must be stressed that the police and customs officers — underpaid and understaffed — have a record on heroin which seems remarkably good.

Since 1980 and the joint study, arrests and seizures have increased dramatically — to 263 arrests in 1983 from eight in 1981 and to 5,263g seized in 1983 from 277g in 1981. In the first months of this year, more than 20,000g were seized.

Medical data are reflecting this increased activity around heroin. Records at the psychiatric wing of Colombo's main General Hospital — which provided the only in-patient medical care for drug addicts until two small wards in regional hospitals were opened earlier this year — reveal no heroin cases until 1982, when there were two. In 1983, 94 were admitted, and 21 in the first three months of this year.

Nalaka Mendis, psychiatrist in charge of the wing, says of an overall total of nearly 200 cases of heroin addiction he has seen in the past nine months, about 70% "came from derelict, impoverished, urban slums." The rest, he says, were fairly evenly distributed socially. Only one was female. Treatment throughout the island is invariably methadone administered in dosages roughly equal to the patient's heroin intake and reduced gradually over a few weeks.

But, as Dr Mendis admits, there are no systematic treatment schedules and absolutely no follow-up; it is all crisis intervention.

Most private doctors shy away from treating addicts, seven doctors, who spoke for themselves and friends, told **The Journal**. Four spoke only "in theory," never having been confronted with a case. The general medical view is that "these are cases" for psychiatrists.

But there are only 20 psychiatrists for the entire country. Said one: "I am happy to give them my time and attention, but I cannot go searching after them. If there is a drug problem, we must have a system and facilities to treat them properly."

But, a "drug problem" is invariably associated with heroin; the broader picture is confused. Certainly, no systematic research has been done.

While cocaine figures large in the new law, if there has been evidence of it in Sri Lanka, the authorities are saying little.

On the other hand, there is evidence Sri Lanka is a transit point; authorities refer readily to the detection in 1981 of a $3.5 million consignment of cocaine being sent to Colombo en route to Australia and New Zealand.

Reinforcing the suggestion are rumors that officials in Holland have information that Dutch nationals are setting up a cocaine-processing factory on the island.

On other drugs, there appears to be consensus. Morphine has "never been" a problem. Opium abuse has been "declining steadily" and is now confined to the "old addicts," most of them laborers. Even some of these have converted to heroin.

Dwindling demand notwithstanding, police say a steady, "if not increasing" supply of raw opium has been coming in — from illicit plantations in Pakistan and leakages from India's licit produce — via old, established, smuggling channels from southern India to northern Sri Lanka. Last year a single consignment of 408 kilograms was seized en route to the island by Indian authorities.

The Police Narcotics Bureau seems confident that no poppy is grown, and that no heroin has been produced here since the 1981 detection of the island's only known heroin factory.

Cannabis, often talked of here as "the drug of choice," has been familiar for centuries, with no record of abuse or addiction. It is part of the pharmacopoeia of the ancient school of indigenous medicine.

There is a vocal lobby which advocates its exclusion from the dangerous drugs list, if not its legalization. Systematic and, police say, still increasing cultivation began in the early years of the tourism phenomena in the mid-1970s.

Since then, an unspecified number of Sri Lankans have been arrested, at home and abroad, for being in the cannabis export business. And nearly 300 Sri Lankans are now in foreign jails for various drug offences, police say.

The cannabis of choice in Sri Lanka has long been the so-called *Kerala ganja*, imported from India and farther afield, which has a much higher tetrahydrocannabinol content than local cannabis.

A significant recent development on the drug scene here came when the smuggling channels for the popular substance were disrupted.

Kerala ganja was being carried into Sri Lanka by small craft stealing across the 22-mile Palk Straits from India. When outbreaks of Sinhalese/Tamil violence brought increased military activity to the area and naval surveillance of the northern seas, the small craft were scared off. Choice cannabis became hard to find, and the gap was filled almost immediately by "brown sugar."

This is the same low-grade heroin which gets to Katmandu mainly via Benares, India (**The Journal**, Aug). It is a Pakistani product which apparently comes direct to Sri Lanka.

No statistics exist for "brown sugar" dependents, but this crude heroin is now widely abused, particularly by urban poor. Although some officials say addiction is spreading "like fire" among boys in the "top" schools, it's possible that while better-off youth do dabble in all drugs, they tend to stay with cannabis, including hash oil.

But the huge majority of the abusers and pushers are poor. A "dose" costs around 25 rupees (Cdn $1.40), a bit more than the price of a cannabis joint or a street dinner; but it can be shared.

For them, the hospital is a hostile place. Even if they seek help, there is no long-term treatment. Follow-up and after-care facilities are totally absent. Everyday advice is negligible, though a group known as the Befrienders runs a small advisory centre. There is no place where post-treatment addicts can talk — to each other or advisers.

The number of addicts is still relatively small, and very few have been addicted for more than a year. But, for those who are addicted, help is what is missing.

Drugs have been treated as purely a police problem for years; the new law may institutionalize that attitude. The danger is that police effort could be dissipated chasing street-level drugs, while the problem of Sri Lanka as a transit station in international drug traffic to Australia, New Zealand, and Europe, particularly the United Kingdom, grows unchallenged.

Report from Gamini Seneviratne in Sri Lanka with Anne MacLennan in Toronto

THE BACK PAGE